Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician/ Sherry Kay Stephen Month Р Medical 2011 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Western MD Regional Medical Center Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 1 Year 8. Date of Birth **Funeral** Months Days Hours Min 1 M 2 Tr 02/26/4948 376-48-4450 63 Michigan **Director** Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director Allegany Cumberland 1 Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 items 23a Funeral 14101 Winchester Road, SW, Lot S 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black. White, etc. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Ith and Mental Hygiene.
27 is marked other than "r
r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve ones. Ramsey Ethel 2 Evelvn Glenwood Blaine Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 107, Pinto, MD 21556 Travers H. Stephen / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cumberland Crematory 06/21/2011 1 Burial 2 X Cremation 3 Removal from State Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. Vi Funeral Service Liverses 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Either the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to Lung & Liver **Examiner** Sequentially list conditions it any, leading to immediate cause. Enter Underlying Examir Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) ned by the a 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 🗌 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes Certificate: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director, After 1 Natural injury 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0056080 June 20, 2011

State Registrar 31. Date filed (Month, Day, Year)

JUN 20 2011

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allison Evans-Wood, M.D., 17204 McMullen Highway, Cresaptown, MD

parks

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Arthur Stemple. Sr. Month Day 2011 June Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 514 Welch Avenue Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours 81 Director 216-22-5020 08/04/1929 Maryland Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 514 Welch Avenue 21502 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Car Foreman Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve James Stemple Enos Olive Grace Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Stemple, Jr. / Son 417 Timber Ridge Road, Frostburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD Vet Cem @ Rocky Gap 06/21/201 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licenses 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ STROKE Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last aron Ary attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE EEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Day Month the 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but n<u>o</u>t resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

State

NLA

5+

3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregg C. Donaldson, M.D.,

2011

31. Date filed (Month, Day Year)

D42054

912 Seton Drive, Cumberland, MD

June 17, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jun 22, 2011 Physician/ 7:55 PM Oscar Smith Jr. Conda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Rawlings 18638 White Oak Drive If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9, Birthplace (State or Foreign 7. Age (In vrs. last birthday Birtnpiac Country) MD **Funeral** Hours Sep 12 Director 214-90-0018 49 "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must harmistical. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Rawlings MD Allegany 1 □xYes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 18638 White Oak Drive 21557 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Local 1024 Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Marion Liller Conda O. Smith, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 18638 White Oak Drive Rawlings MI MD 21557 Terri Smith wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 3 Amemation 3 Removal from State Scarpelli Funeral Home, P.A. 6/23/201 MD Cresaptown 5 Other (Specify) 4 Donation ignature of uneral Service 22. Name and Address of Facility Paral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition Physician Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to edical 26. Place of Death (Check only one) Hospital 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pendina 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number ause of death (Item 23a) (Type, Print) State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 22, Day 3:00 PM Rode11 2011 Lawrence Spriggs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Cheverly Prince George's Community Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 213-24-3279 **Funeral** Hours 1 XM 2 □ F 10-27-1927 Collington, MD 83 **Director** Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits 10a. State and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at Director Prince George's Upper Marlboro MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 United States 10200 Prince Place #207 12. Was Decedent Ever in U.S. Forces? 1946and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1947 1 ☐ Yes 2 X No Specify: Completed 3 - Widowed 4 - Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.P.S 12 Mail Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hawkins Richard Spriggs other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10200 Prince Place #207 Upper Marlboro, MD 20774 item 27 i Mercedes O. Spriggs (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 X Burial 2 Cremation 3 Removal from State 6/30/2011 MD Veterans Cemetery Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funer Service I censee Brentwood, MD 20722 3401 Bladensburg Road thon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the my de of dying, such as cardiac or respiratory Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to Or as a co Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the a should be detached g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: ျ 1 Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheverly, MD 20785 JAMES CATEVENIS, MD 3001 Hospital Dr

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

JUN 2 8 2011

32. Registrar's

			Please Type or Print					-	e.		
			State of Mai	ryland / Depa			lental Hy	giene	22005		
+lb		-	Registrar 1. Decedent's Name (First, Middle, Last)	<i>Cei</i>	rtificate of I	Death	2. Date of De	Reg. No.	3. Time of Death		
100	Physici /Medic		LUCY PEARL S	Month June	ear 11 11:10A ^M						
	Examin		4a. Facility Name (If not institution, give street and number)	0		r Location of Death		4c. County of	Death		
		a.	Alice Byrd Tawes Nursin 5. Social Security Number 6. Sex 7. Age	-		field If Under 24 Hrs.	8. Date of Bir	merset			
	Funeral Director	1 M 27 F Months Days Hours Min. (Month, Day							th 9. Birthplace (State or Foreign Ay, Year) 9. Birthplace (State or Foreign Country) Maryland		
	p		Usual Residence of Decedent	10c. City, Town or Lo			03/23	7 1 2 1 0 121			
	Aaryla f shov ed at	ō	_	Toc. City, Town or Lo		isfield			10d. Inside City Limits		
	r 28a- notifi	Directo	Maryland Somerset 10e. Street and Number		10f. Zip Code	ISTIETU		10g. Citizen of Wha			
	th with		67 Richardson Avenue		2	1817			USA		
	er dea	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	rer in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Black,	American Indian, White, etc.		
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give ↑ 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 □XNo	Specify:		Specify:	White		
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Maryland 21215-0036	0 6 50 10		19a. Informant's Name/Relationship (Type. Print)	1				per, City or Town, St			
	is 1 and of Health item 27 other tr		Terry D. Sommers (Son) 20a. Method of Disposition	1			- POCO	moke, MI			
altimore,	Pages nent of int: If its iry or o		1√ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo		1			sfield, MD		
alti	permit. Pages Department of Important: If It any injury or once.		21. Signature of Frineral Service Licensee	22	2. Name and Addre	ss of Facility Bra	dshaw	& Sons	Funeral Home		
<u> </u>	8 8 E 8	1	Mary Beth Bradshaw-Pr					ield, MI	21817		
		8	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final	ne death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death		
9	Physician /Medical		disease or condition resulting in death)	consequence of):							
	Examiner										
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x 687	death certificate be e attending physicia d for use as the bur	Physician/Medica	IF FEMALE:								
. Box	leath c attend for us	cian,	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome please in the past 12 months? 4□Pregnant at ti	Fetal death 3		23d. Date of delivery Month Day Yea					
O	at the c by the tached	hysi	1 □ Yes 2 No 9 □ Unknown 9 □ Unknown								
JS,	w requires that the di been signed by the should be detached	by	Part II. Other significant conditions contributing to death but $ASCVD$	not resulting in the u	nderlying cause giv	en in Part I.		23e. Did tobacco use contribute to the cause of death?			
500	v requisions	eted	7,320						☐ Probably 4 ☐ Unknown		
Vital Records,	sician: The law requires that the certificate has been signed by the irector, page 2 should be detache	Completed						ppsy pri- ormed? dea	ere autopsy findings available or to completion of cause of ath?		
		Be C	25. Was case referred to medical examiner?			26. Place of Deat	1 Yes h (Check only		Yes 2□ No		
<u>7</u>	Physic this ce	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient			4 Nursing Ho	me 5 Res	idence 6 □Other	(Specify)		
Division or	ding P	Certification:	27. Manner of Death 1 X Natural 5 Pending (Month, Day) 2 Accident investigation	Yea <i>r</i>) 28b. Time o	Wor	yat k? Yes 2 ⊡ No	28d. Describe	how injury occurred			
N SI	after death Director:	ifica	a Could not be	y - At home, farm, str			28f. Location	(Street and Number	or Rural Route Number,		
5	pltal or ours afte eral Dir filled in	Cert						wn, State)			
	To the Hospital or Attending Physician: white 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director, the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director director director.	Medical	29a. Certifier (Check only one) Medical Examiner: On the best of Medical Examiner: On the basis of each one)	examination and/or in	h occurred at the til evestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time	e cause(s) and mani e, date and place, an	ner as stated. nd due to the cause(s)		
	To the Hospital within 24 hours a To the Funeral I completely filled	Me			29c. Licens	e number		29d. Date signed ((Month, Day, Year)		
	IN		· a cont	-07	D	48098		6/20/	12011		
7	10,0		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print) 201 1	teul this	lume	(Srife	ld MD 21817		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar	's Signature				1,30,0	(Month, Day, Year) 12011 12, MD 21817		
×	Registr	ar	JUN 2 2 2011 Lana	un B. ,	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State of N	/larylan		artment <i>tificate</i>			Mental Hy	giene Reg. No.2	4	22006
	Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death								≱ %′1	3. Time of Death		
-	Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of E											
	<u> </u>		22233 Nar 5. Social Security Num							tin	a La Data at Bio			icomico
ı	Funeral Director		220-20-39	959	M 2 □ F	8		If Under 1 Months		Hours Min			Got	thplace (State or Foreign untry) Maryland
	and show	tor	Usual Residence of De 10a. State 1	ecedent 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	ne Maryland or 28a-f shov notified at)irec	Md.		omico		Tyas							1 ☐ Yes 2 🛣 No
	ath with the	eral	10e. Street and Number 22233 Nar		Road			10f. Zip 0	ode 21865	5		10g. Citizen o Unit		untry? tates
,	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married		12. Was Decedent Armed Forces	0		Vas Deceder Yes, specify	t of Hisp Cuban,	anic Origin? (S Mexican, Puer	Specify Yes or No- to Rican, etc.)		ace - Amer	rican Indian,
036	e filed within 72 hours after des ttal Hygiene. ed other than "natural", or ite event, the Medical Examiner	ed by	3 Widowed 4		If Yes 2 L If Yes, Give Year or Dates.	If Yes, Give 1057 1 Yes 2 No Specify: Spec								White
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212	d within lygiene. her th a	os l	Elementary/Second			College (1-4 or 5+) life. DO NOT use retired) Waterman							Seafo	od
and	l be filex lental H rked ot tic ever	To B	17. Father's Name <i>(Fir</i> Hoy	st, Middle, Last) yt Somer	is metter of tarre (neg						_{ame (First, Middle,} .rbara La		,	
, Maryland 21215-0036	ge 1 and 2 should be it of Health and Men if item 27 is marke or other traumatic		19a. Informant's Name Mary Lou		Type, Print) :Wife		19b. Mailin 22233	g Address (S Nanti	treet and	Number or Re	ural Route Numbe Tyaskin	r, City or Town,	State, Zip 218	
altimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Dispos 1 Burial 2 4 Donation 5	Cremation 3	Removal from Stat	_ C6	lace of Dispo- emetery, crem • Pete	natory or other	er place)	EME. 06	Date -23-2011	20c. Location	le,	·
Balt	permit. Depart Import any inj		21. Signatore of Funeral Service Licensee 22. Name and Address of Facility HINMAN Funeral Home 11673 Somerset Ave. Princess Anne.										d. 21853	
			23a. Part I. Enter the shock, or heart fa Implediate Cause (Fin	failure.List only	plications that cause one cause on each li	ed the death ne.	ı. Do not ente	r the mode o	of dying, s	such as cardia	c or respiratory an	rest,		Approximate Interval Between Onset and Death
C	Medical		di se or condition resulting in death)	•	a. Due to (or as	a conseque	ence of:	path	Y					Onostano Doubi
	Examiner													
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0	ate be executed ohysician and the burial-transit	edical Examiner	resulting in death) Las	st	Due to (or as	s a consequ	ence ot):							
68760	rtificate ling phy e as the		F FEMALE:		00- 15									
. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pre in the past 12 mo 1 Yes 2 N 9 Unknown	onths?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal at time of d	death 3 _	Ectopic pre Other (spec	gnancy ify)				ate of deli Ionth	ivery Day Year
ls, P.O.	uires that ti n signed by		Part II. Other significa	ant conditions	contributing to death	but not resu	ulting in the u	nderlying cau	ise given	in Part I.	23e. Did to	\		the cause of death?
Records,	The law req ate has bee bage 2 shor	Completed by							<u></u>		24a. Was autop perfo			copsy findings available completion of cause of
ital	ician: Tertifica		25. Was case referred examiner?	•	Hospital:				Othori	of Death (Che	eck only one)	Z NO		
of Vital	ig Phys ter this neral dii	te: To	27. Manner of Death	No	1 ☐ Inpa 28a. Date of inj (Month, Da	ury :	R/Outpatien 28b. Time of injury		Injury at work?		Home 5 Resid			(fy)
Division	ttendir death. stor: Af	Certificate:	2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigatio 6 ☐ Could not b	n			М	1 🗆 Yes	s 2 🗆 No				
Divis	ital or A irs after al Direct led in by	<u>e</u> [4 ∐ Homicide	determined	building, e	tc. (Specify)					City or Tow	n, State)		al Route Number,
	he Hospi in 24 hou he Funer ipleted fil	Medical	(Check 24L	J Medical Exam	sician: To the best o iner: On the basis of se Practioner: To the	examination	and/or investi	gation, in my	opinion, o	death occurred	at the time, date a	nd place, and d	ue to the c	ause(s) and manner stated.
	Tot Tot Con		29b. Signature and title	e of ceutifier	11		M	29c. L	cense nu	imber	78	29d. Date sign	ed (Month	, Day, Year)
	10°	1	30. Name and address	of person who	completed cause of	death (Item	23a) (Type, Pi	05 P/C	E	POB	OX17:	33 5	olist	1 my 2/80
	Stat Registra	~	31. Date filed (Month, D	Day, Year) IUN 22		rar's Signatu	A. A	back	,				(21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:30AM V. Scott 22 2011 Diane 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pocomoke City Worcester Davey's Assisted Living If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3 - 12 - 1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🔀 F Maryland Director 89 218-76-4134 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expression rust be notified at Worcester Pocomoke City 1 Yes 2 No Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 302 Market Street 21801 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1

Never Married 2

Married 1 ☐ Yes 2 No Specify Specify. 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuary injury or other traumatic event any injury or other traumatic event. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Race St., Apt. 208, Cambridge, MD 21613 M.Marie Daniels/Niece 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Thompsontown, MD 6/27/2011 4 ☐ Donation 5 ☐ Other (Specify) Thompsontown Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Framptom Funeral Home, Federalsburg, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy been signed by the atte should be detached for Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 13 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Maryland 21215-0036

1604-Market 31. Date filed (Month, Day, Year) State Registrar

duto

29b. Signature and title of certifier



SARAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5%



R. BARAL N

POCOMOKE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

54422

29d. Date signed (Month, Day, Year)

06-22-201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phyllis H. Summers July July 2011 5:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Crumland Farms Health Center Frederick Social Security Number g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth Months Days 1 M 2 M F 83 218-24-9309 August 13. Maryland Director Usual Residence of Decedent shov 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 28a-f Frederick Frederick Maryland 1 X Yes 2 No 10e, Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21,702 7407 Willow Road United States of America death 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. White Specify: "natural", Completed 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own. Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic even ၉ Helen Beall Robert Douglas Hemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other tra Robert C. Summers / Son 8203 Glen Heather Drive, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Mount Olivet Cemetery July 7, 2011 Department of Important: If any injury or Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 Fast Church Street, Frederick, Maryland 21701 Signature of Funeral Service Line see M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ STENIOSIS disease or condition AORTIC Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical death certificate be P.O. Box 68760 as the t IF FEMALE: asi yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No jo Month Pregnant at time of death ed by the a detached if 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, WABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 🏲 Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29d. Date signed (Month, Day, Year) 021936 MD 2011

State Registrar

JO 24

THOMAS VOHISION DRIVE FREDERICK MY 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

65C 32. Registrar's August

.DONELSON

11-04942

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onald Lester Tetl		St For State	ate of Maryl			ent of			Menta	l Hy		leg. No.	20	Aberro.	22009
Physician Medical Examine	1/	egistrar I. Decedent's Name (First, Midd Donald Les							-	2	2. Date of Dea Month July 2, 20	ath Day	Year	1	3. Time of Death 1335 hrs
)	Í	a. Facility Name (if not institution Western Maryland He		umber)		41	c. City, To		ocation of I		4c. County of Death Allegany				
Funeral Director		5. Social Security Number 579-52-0018	6. Sex	7. Age (In yi		thday) Yrs.	If Under Months		If Under 2 Hours	24Hrs. Min.	8. Date of Bi	/193	D/YYYY) 8	9. Birth Foreign Cour	place (State or Datry)
aryland Sa-f show aoy af ooce.	jo_	Usual Residence of Decedent 10a. State 10b. County MD A 10e. Street and Number	10c. C	City, Towr	or Location	mber] 10f. Zip C							10d. Inside City Limits 1 X Yes 2 No		
er death with t	runeral	135 N. Mechan 11. Marital Status 1 Never Married 2 M 3 X Widowed 4 Div	arried 12. Was De Armed 1 X Yes	ecedent Ever in Forces?	n U.S.	If Ye	Decedent	Cuban, I	anic Origin Mexican, P		cify Yes or N tican, etc.)		US 4. Race - White,	Americ	an Indian, Black, White
1215-0036 d be filed within 72 hours af fenda Hygiene. sarked other than "natural report, the Medical Examin	mpleted b	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	cify only highest grand		d) 16a.	Decedent during mo		ng life. D	O NOT us	se retire					dustry
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	9	17. Father's Name (First, Middle Arthur 19a. Informant's Name/Relations		Tetlow		b. Mailing	Address		Emma	a	ıral Route Nu	Pi	.er	, State,	Zip Code)
Baltimore, MD 2 seruit. Pages 1 and 2 shou Department of Health and Important: If item 27 is no injury or other frauent.	1	Darlene Norri 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other S	n 3 Removal	from State	0b. Place crema	of Disposit story or other t Cen	ion (Name erplace) n. @ C	of ceme	etery, nsvili	le (Date)7/11/2	20c. Lo	Cro	City or T	erland, MD own, State 1502 ville, MD Home, P.A.
	1	21 Signature of Funeral Service 23a. Paul I. Enter the disease, or	ann	caused the de	eath. Do r	40)4 De	catu	r Sti	reet	c, Cumb	perla	ınd,	MD	21502 Approximate Interval
Physician /Medical xaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <u>Hypert</u>		Athe										Between Onset and Death
	m line	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	a consequence								_			
e executed vian and rial - transi	dical Ey	X UNPENDED	d AMENDED	23a,p	t.II	,27,p	er me	, g91	7 7-2	28-1	1 sm			-	
iton of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be executed leath. for: After this certificate has been signed by the attending physician and the fineral director, page 2 should be detached for use as the burial - transit	읽	IF FEMALE: 3b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	he 1 Live	, outcome of p birth gnant at time o	f .la .akb	2 Feta	al death er (Specia	3 [fy)	_Ectopic p	oregnan	су		Date of o		ay Year
P.O.		Part II. Other significant condi Diabetes Mel		to death but r	not resulti	ng in the ur	nderlying o	cause giv	ven in Part	I.	1 Ye	es 2 🗹	No 3	Proba	he cause of death? ably 4 Unknown opsy findings available
tal Records ciso: The law requi certificate has been ector, page 2 should	e Completed by	25. Was case referred to medical					26		of Death (C	heck o	1 Yes	ormed? 2 No	de	eath?	ompletion of cause of
Division of Vital Records, rat or Attending Physiciae. The law require after death. Al Director. After this certificate has been signed in by the funeral director, page 2 should been in the funeral director, page 2 should been as a standard or a should be a	ation: To Be		Hospital: 1 28a. Dai (Mor	Inpatient 2 te of Injury th, Dey,Year)		Outpatient . Time of In		Bc. Injury	other 4 1	40	Home 5		ту оссите		-
. ७ ∢ ∺ ഉଛ .	Certification:	3 Suicide 6 Cou	ald not be ermined (Specif								or Town,	State)			al Route Number, City
0 ~ = >1	edical	one) 2 Medical Exa	Physician: To the basi aminer:On the basi and manner	s of examination	viedge, de on and/or	eath occurr investigati	on, in my	opinion,	death occu	e, and ourred at	the time, dat	e and plac	ce, and du	ue to the	cause(s)
		29b. Signature and title of certifications of the second s	hall, m	<u>)</u>			29c.	O.C.N					3, 201		th, Day,Year)
		30. Name and address of person Pamela E. Southall,	MD Assistan	t Medical E	Examin		W. Bal	timore	Street,	Baltin	nore, MD	21223			
Sta Registr	te ar	31. Date filed (Months Pay, Year,	1 2011 32.	egistrar's Sig	nature	pa	Ker								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 9, Day 2011 Year June Physician/ 14:55 Tramun, Jr. J. Willie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min Feb. 6, 1950 New York 1 🔀 M 2 🗆 F 61 Director 083-42-2003 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho I Examiner must be notified at Director DC Washington none 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20019 U. S. A. Completed by Funeral 4925 Quarles Street, N. E. Apt. 101 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Important of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Restaurant Cashier 12th Be 18. Mother's Name (First, Middle, Maiden Sumame)
Mary Barrett 17. Father's Name (First, Middle, Last)
Willie James Tramun, Sr. ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Upper Marlboro, Md. 60 Joyceton Terrace (Sister) Gillian Bates 20c. Location - City or Town, State Washington 1D-C Ma 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery of cemetory of other place)
Enwood Cemetery
headpearce Crematory 1 Surial 2 Formation 8 F 4 Donation 5 Other (Specify) -8 ☐ Removal from State 6-23-2011 22 Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N. W. Washington, Signature of Funeral Service Libensee D.C. 20010 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mohary Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and a pompleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Month Pregnant at time of death 2 No 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 Who 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 Wo Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 4No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060100

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

Almines

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6/27/2011 Vear $1015am^{M}$ Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Anne Arundel Hanover 1402 Macedonia DR. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** Months Days Hours 12/14/1939 1 🗷 M 2 🗆 F 71 Director 345-32-9097 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item. 10b. County 10c. City, Town or Location 10a. State Director 1 Yes XX No Hanover Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21076 1402 Macedonia DR. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married XX Married XX Yes 2 No þ Black 1 Yes XX No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates.Vietnam 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Army Claim Investigation 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Lillian Keys Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hanover, MD 21076 1402 Macedonia Dr. Phrizilia Thompson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA 7/21/2011 Arlington National 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 7/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year in the past 12 months? Pregnant at time of death 9 Unknown been signed by the s Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed has death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work' Natural 5 Pending Accident 1 Tes 2 🗌 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) le of certifie 29b. Signature 10 % Karl Kasamon and address of person who completed cause of death (Item 23a) (Type, Print Dr. HOS

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ F. June Day 2011 ear Patricia Varney 20. 13:57 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death College Park .County of Death Prince George's Examine 5206 Kenesaw Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Hours 160-22-7539 81 Sept. 10, 1929 Pennsylvania **Director** Yrs. Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10b. County 10c. City, Town or Location College Park with the Maryland 10d. Inside City Limits Director Prince George's Maryland 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5206 Kenesaw Street 20740 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White "natural" 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot ir other traumatic ever William Patrick Flanagan Elizabeth Grieninger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11845 Tall Timber Drive Clarksville, Maryland 21029 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Michael Varney -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Metropolitan Crematory 6/25/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Bonard Av. Bbrewardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 V 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ∤nysician/ 20 years Chronic Obstructive Pulmonary Disease disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Bronchitis; Atrial Fibrillation 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death?
1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending Investigation 6 Could not be □ Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 21, 2011 8 D26287 religa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. Berard, M.D. 7305 Baltimore Avenue, #107 College Park, Maryland 20740 31. Date filed (*Month*, *Day, Year*) **JUN 2 3 2011**

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. Year 9:16 pm TINTERPOOL Medical JUI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Marandi Assisted Living Facility Prince George's Bowie If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day,
Dec 29. **Funeral** Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign Day, 1 M 2 WF Months Days Country) Yrs. **Director** 144-54-0019 50 1960 show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Prince George's Bowie 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 12429 Starlight Ln. United States of America 20715 items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, et þ 1 Never Married 2 Married Specify: Caribbean Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed American injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life, DO NOT use retired. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Employee Benefits Manager **Human Resources** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benito Vanterpool Doreathea, Goins and P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Pace A. Duckenfield/husband 12429 Starlight Ln. Bowie, Md 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory |Jun 29,2011 |Beltsville, Md . Sign ture of Funeral Service Licensee 7400 Georgia Ave. 22. Name and Address of Facility McGuire Funeral Service Inc. Wash., DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) for use as the burial-transit that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknow cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law autopsy performed certificate ! Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this to the Funeral Director: After the completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State

Registrar

ne and address of person

JUN 2 3 2011

Date filed (Month, Day, Year,

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gordon Frederick 201 I Year Jüne 18, 2:33 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Kensington Park Retirement Community Kensington Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Country 085-14-2995 1 X X 2 - F Hours Min. Nov. 29, Year) 923 87 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3618 Littledale Road 20895 IISA "natural", or items 12. Was Decedent Ever in U.S.
Armed Forces?
12 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: White 1 ☐ Yes 2 ☒No Specify: 3 Divorced 4 Divorced Completed WWII Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I Safety Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental Fig. 7 is mark. Geneva Rosenbarker Lorne C. Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana Maria Ward/Daughter 3421 University Blvd. West, #103, Kensington, MD 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date June 21, 2011 cemetery, crematory or other place Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of F neral Service Vicensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physiciany Coronary Artery Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a control tience of and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Mellitus Division of Vital Records, 1 ☐ Yes 2 HNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 5 29d. Date signed (Month, Day, Year) Do June 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #606

Bradley J. Hunter, DO 10400 Connecticut Avenue, Kensington, MD 20895

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 1 2011

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Joseph,

31. Date filed (Month, Day, Year)

IIIN 22

D0060634

1160 Varnum Street, #021, Washington, DC 20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLOTTE M. WASHINGTON 06720/2011 2:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Gensis Health Care Ctr Rockville Montgamery 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🛛 F 1071571946 Director 215-46-2157 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland irrent of Health and Mental Hyglene. That: If flet mg 27 is marked other than "natural", or items 23a or 28a-f sho iury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No MD Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? Funeral 17700 Town Crest Drive, #204 20877 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Noivorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Sample Apolonia Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Lyn Moser/daughter 6783 Veronica Court, St. Augustine, FL 32086 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or Ardent Cremation Sv 06/22/11 4 Donation 5 Other (Specify) Hanover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home TOX 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart drure. List only one cause on each line. 23a. Part 1. Enter the Interval Between
Onset and Death
Several years Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Cardiamyopathy Medical Due to (or as a consequence of): Examiner Con estive Heart Failure 3 weeks Sequentially list conditions if any, leading to immediate Examine cause. Enter Underlying -trainsit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the atter in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypertension Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should een: Chronic Kidney Disease 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 X No prior to completion of cause of After this certificate 1 ☐ Yes 2 🗓 No I or Attending Physician: after death.
Director: After this certified 25. Was case referred to medical examiner?
1 ☐ Yes 2 ເX No Completed filled in by the funeral director Be 26. Place of Death (Check only one) Other: 4 XNursing Home 5 Residence 6 Other (Specify) Hospital ပု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital o within 24 hours aft within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Haynos, CRNP 31. Date filed (Month, Day, Year)

JUN 2 3 2011

R113971

10110 Molecular Drive, #206, Rockville, MD 20850

06/21/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christina L. Sco		1- For State	tate of Maryla		artment o rtificate o		d Mental		2 0 Reg. No.	11 2201
Physicia		1. Decedent's Name (First, Middle, Last) Christina L. Scott 2. Date of Death Month Day Year								3. Time of Death
Medical Exami	ner	Christina Louise Windsor Scott June 26, 2011								0030 nrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De Suburban Hospital Bethesda Montgomer								
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year			irth(MM/DD/YYYY)	Birthplace (State or Foreign
Director		220-80-2488	1M 2XF	5	1 Yrs	Months Days	s Hours M	04/29	9/1960	Country) Maryland
h		Usual Residence of Decedent		Idon Cibe	, Town or Local					10d. Inside City Limits
A										1 X Yes 2 No
Maryland 28a-f show	녆	Maryland Mont 10e. Street and Number	gomery	<u>F</u>	Rockvil	Le 10f. Zip Code		T	10g. Citizen of Wha	
or 28	ig E	1906 Valley St	room Driv			20851		ŀ	TIm d to al	States
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U		s Decedent of His	panic Origin? (o- 14. Race -	American Indian, Black,
death or iten	in in		farried Armed F	2X No	If Y	es, specify Cuban		rto Rican, etc.)	White,	etc.
s after ral",	2		vorced If Yes, Give Yea or Dates:		1	Yes 2 X No		et considerate	Specify: 16b. Kind of Busi	White
2 hour	Completed	 Decedent's Education (Spe Elementary/Secondary (0-12) 				nt's Usual Occupat ost of working life.			100. Kind of Busi	ness/industry
336 thin 72 than	e d	12	as mage (S	elf Emplo	oved		Home Re	modeling
5-0 led wi Hygier of her		17. Father's Name (First, Middle	, Last)	-				me (First, Middle,	Maiden Surname)	
21215-0036 Muld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Be	Melvin		Windso					eth Loui	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heathh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injuty or other traumatic event, the Medical Examiner must be notified at once	-1				1.0	-			mber, City or Town,	
ages 1 and 2 shount of Health and Nat. If item 27 is not other traumatic	H	Candyce Hevener 20a. Method of Disposition		20b.	Place of Dispos	ition (Name of cer		Date		and 21850 City or Town, State
Baltimore, permit. Pages I an Department of Hei important: If ite		1 Burial 2 X Crematio		UIII State	crematory or ot	_{her place)} tan Crem	0.7	/02/2011	Alexand	ria, Virginia
Baltir permit. P Departme Importar	_	4 Donation 5 Other S 21 Signature of Funeral Service		0 0	22.1	lame and Address			eral Home	
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Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause		aused the death	. Do not enter t	he mode of dying,	such as cardiad	c or respiratory ar	rest, shock, or hear	Between Onset and
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	-	Sequentially list conditions,	b.	consequence c	л).					
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b	Examiner	(Disease or injury that initiated events resulting in death) Last	C	consequence o	of):					
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5876 srtifica ling ph	an/N	23b. Was decedent pregnant in t past 12 months?	he 1 Live b	pirth	2 Fe	tal death 3 [Ectopic preg	nancy	Month	Day Year
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D. B trhe d		Part II. Other significant condi			resulting in the u	ınderlying cause g	iven in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rafter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d b					_		_ 1 ☐ Y€	es 2 No 3	Probably 4 Unknown
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tal Rec	Be	25. Was case referred to medica examiner?					of Death (Chec	ck only one)		
Physic r this or	ᇍ	1 ✓ Yes 2 No		Inpatient 2						Other:
n of viding Ph	Ë	27. Manner of Death 1 X Natural 5 Pen	28a. Date (Month	or injury , Day,Year)	28b. Time of I	· · _ ·	yatWork? ′es 2 No	28d. Describe	how injury occurred	•
isior Attend rector: by the	icat	2 Accident Inve	stigation 28e Plac	e of Injury - At h	ome, farm, stree	et, factory, office b		28f. Location	(Street and Number	or Rural Route Number, City
DIVI	Certification:		Id not be (Specify)					or Town,	State)	
the Hor nin 24 h the Fur	Medical C	29a. Certifier 1 Certifying P	hysician: To the bes	of examination a						
と呼ら	Me	29b. Signature and title of certifi	and manner s	tateu.		29c. License	e number		29d. Date signed	(Month, Day, Year)
		1 antira	eoul)			O.C.N	M.E.		June 27, 20	11
		39. Name and address of person				ltimera Ct	Dolling	MD 24222		
4.2	ate		ssistant Medica	egistrar's Signa		altimore Street	., Dailimore	, IVID 2 1223		
Regist	_	31. Date filed (Month, Day, Year)	11377 123	we B	gar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Wratchford Physician/ Marie 5:30 P 2011 June 4c. County of Death Allegany Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Cumberland 1210 LaFayette Avenue 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1077371926 1 □ M 2 😾 F Pennsylvania 84 212-24-2138 **Director** Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland Director Cumberland 1 X Yes 2 No Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 1210 LaFayette Avenue Funeral USA 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) (unknown) Clara 9 Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1210 LaFayette Avenue, Cumberland, MD 21502 Douglas L. Wratchford / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 06/20/2011 Cumberland, 22. Name and Address of Facility Adams Family Funeral Rome, Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and wath Us care Immediate Cause (Final Imona Physician noon disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter in the past 12 months? Day Year jo Pregnant at time of death 2 No 9 Unknown been signed by the sahould be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 page 2 s has death? 1 Yes 2 No Yes this certificate After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No death. Accident Investigation within 24 hours after death

To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Aractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) June 20, 2011 29b. Signature and title of certified 29c. License number

State

2/1

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DHMH 17 Rev 7/2009

31. Date filed WNth, 200-2011 Registrar

30. Name and address of person who comp

Sunil K.

M.D.,

Gupta,

leted cause of death (Item 23a) (Type, Print)
M.D., 625 Kent Avenue, Cumberland, MD

D33280

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gary Ivan Wise 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10mic If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign PA Country) Months Days 9/2/1937 1 X M 2 🗆 F Hours 73 **Director** 163-30-5410 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at by Funeral Director 28a-f 1 Yes 🛣 No MD Berlin Worcester 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o any injury or other traumatic event, the Medical Examiner must be 158 Ocean Parkway 21811 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Marylahd 21215-0036 white If Yes, Give Year or Dates. 1 ☐ Yes 2 K No Specify: Specify 3 Widowed 4 Divorced Completed Army 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Grace Hetrick Ivan Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ocean Parkway, Berlin, MD 21811 Bonita Lee Wise (wife) 158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1st State Crematory 6/24/2011 Millsboro DE 4 Donation 5 Other (Specify) 21. Signatur of Fyn, ral Scripe Licensee 22. Name and Address of FacilityThe Burbage Funeral Home 108 William St. Berlin, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between Onset and Death shock Immediate Cause (Final Ph_sician/ Dromyo disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. signed by the attending physician and defached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nhknown been signatures should to 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo 24a. Was an autopsy performed After this certificate has director, page 2 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: HCS PIEZ မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WAM

HULAM

2

31. Date filed (Month, Day, Year)

0005 8410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04877 State of Maryland / Department of Health and Mental Hygiene Steven Ross Williams, Jr. 4. Ear State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ 1612 hrs June 30, 2011 **Medical Examiner** Steven Ross Williams. 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Talbot Easton Easton Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. oreign Davs Hours Months Director 212-08-2938 Country) 1X M 2 F MD 41 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 No Federalsburg Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and "natural", or items 23a or 28s-f sho route: If items 23 a nor 28s-f sho or other than "natural", or items 23a or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once Dorchester Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe 21632 United States 7232 Hubbard Road 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: 4 Divorced Specify: White 3 Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Food Processing 12 Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Steven Ross Williams, Sr. Charlotte Walton Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7232 Hubbard Rd. Federalsburg, MD 21632 Gail Williams/Spouse 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Cem . Burial 2 Cremation 3 Removal from State Hurlock, MD 7/6/11 Unity-Washington Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee House CFSP Framptom Funeral Home, Federalsburg, Approximate Interval 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Pulmonary Emboli Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed after death. attending physician and or use as the bunal - tran Physician/Medical AMENDED 23a,27 per me g917 7-21-11 vt W UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day 1 Live birth Fetal death for use as 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed 1 Yes 2 No 3 Probably 4 Unknown Ŕ pleted 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 1 Yes No 28a. Date of Injury (Month, Dey,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification 1 X Natural 1 Yes 2 No Pending Director: Accident Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 | | Could not be Suicide 24 hours a determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29h Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) O.C.M.E. July 1, 2011 whom 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20°11 JULY CHANNING ISIAH WHITFIELD 1:54 A^{M} Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MD HOSPITAL CLINTON CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days JULY 4, 2011 1 🛛 M 2 🗆 F 34. MARYLAND **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo WALDORF MD CHARLES o 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8917 COTTONGRASS STREET 20603 U. S. A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Black, White, etc. ō 1 Never Married 2 Married δ Yes 2 XNo 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked c ge 1 and 2 should be fint of Health and Mental: If item 27 is marked 2 KIMBERLY DECHELLE MORRISON CHRISTOPHER LEE WHITFIELD 19a. Informant's Name/Relationship (Type, Print) FATHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTOPHER L. WHITFIELD 8917 COTTONGRASS ST., WALDORF, MD 20603 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Page 1 Department of Important: If it any injury or conce. 1 Burial 2 Coremation 3 Removal from State METRO . CREMATORY JUL.7,201 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) SERVICE, P.A. 22. Name and Address of Facility RAYMOND FUNL. me of Funeral Service Licen Loser L Banton 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 5e Physician/ URVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner rema Sequentially list conditions il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Exami death certificate be executed -tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed? 2 No 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 M No 1 MInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. Natural 5 Pending within 24 hours after deaun.

To the Funeral Director: After the funeral by the f 1 ☐ Yes 2 ☐ No 2 Acciden Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier (Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JABER

32. Registrar's Schature

MD

7503

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

SUPPATTS ROAD CLINTON MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death June 13 Day 2011 Year Physician/ 1924 Yossa Youmto Colette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Examiner Southern Maryland Hospital Clinton Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🔀 Months Days Hours 41/201/1945 Cameroon none 66 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location
Washington 10d Inside City Limits 10b. County Director DC 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral death with 20032 Cameroon Southern Avenue SE 1234 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Completed by 72 hours after Black Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) during most of working (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nurse permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, <u>th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unk. Tchokoceu unk. Youakeu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6716 Sand Cherry Way Clinton, Maryland27035 Emilie Youmoto/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Kempoval from State 7/30/2011 Family Cemetery Banjou, Cameroon 4 ☐ Donation 5 ☐ Other (Specify) PHYLLP ADSRIVALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Çırysician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a c requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a ng physician as the burial Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death Day Year signed by the a 9 Unknown q Unknown Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician; The law autopsy performe this certificate has 2 **X**No 2 🗌 No Yes 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Director: After Natural
Accider
Suicide 5 Pending work death. М 1 Yes 2 No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To prtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Cetta MD 7503 Surratts Rd Clinton, Md 20735

Registrar DHMH 17 Rev 7/2009

State

Michael Cetta

31. Date filed (Month, Day, Year)

JUN 2 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALKERMA NINONA JULY 2011 Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (if not institution, give street and number) Examiner ANNAPOUS ANNE ARUNAL ANNE MEDICAL 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** 1 □ M 2 🔭 Months Hours Min. 88 544-16-2877 Director 02/15/1923 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location **Crofton** aţ 10a. State Director Anne Arundel MD ral", or items 23a or 28a-f s Examiner must be notified 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21114 Funeral 1721 Good Hope Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 12 should be filed within remains and Mental Hygiene.
n 27 is marked other than "natural", or þ 1 Never Married 2 Married filed within 72 hours after all Hygiene. Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Education College Professor Be 18. Mother's Name (First, Middle, Maiden Surname) **Ivy Lake** 17. Father's Name (First, Middle, Last) Ϊvy မ Bruce Hulse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1721 Good Hope Drive, Po Box 3473, Crofton, MD 21114 19a. Informant's Name/Relationship (Type, Print)
Alice E. Uddin / Daughter permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 7/13/2011 Final Journey crem. 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall DIN SU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ HEART FAIWRE CONCESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical I or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown been signed by the atter Month Day Year Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown PREUMONIA page 2 should 24b. Were autopsy findings available prior to completion of cause of death? MULTIPLE SCLEPOSIS 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No Yes 2 No After this certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Malinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) D70865 JULY (0) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL INFLUMY ANNAPOUS MD ZIUDI (m 2001 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 2011 Physician/ JULY ROBERT 3:00 AM BANNERMAN L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 2022 HAYDEN ROAD HYATTSVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** Sex 1 X M 2 ☐ F Month, Day, NORTH CAROLINA Director 215-46-9514 63 T947 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2022 HAYDEN ROAD 20782 USA ıral", or items ? I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 NAirforce Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 2 YRS Elementary/Seconday (0-12) BUYER-IRS GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ WILLIAM ROSCOE BANNERMAN MILDRED A. SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROWFIELD DRIVE RALEIGH, GARRICK WALKER/SON NORTH_CAROLINA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation, 3 Pemoval from State permit. Page Department Important: It any injury or TATE CEMETERY 7/13/2011 BURGAW, NORTH CAROLINA 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. gnature of Funeral Swice Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC PROSTATE CANCER Medical Due to (or as a consequence of Examine LIVER FAILURE Sequentially list conditions. Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Month Year Day Yes 2 No detached 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 autopsy performed' death'. 1 ☐ Yes 2 X No 1 🗌 Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 XNo ပ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7, 2011 D31586 JULY anci 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NANCY DAWSON MD 3800 RESERVIOR ROAD N.W. WASHINGTON, DC 20007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ THELMA BROWN \mathbf{P}^{M} JULY 2011 1:16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BOWIE HEALTH CENTER PRINCE GEORGE'S BOWIE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days FEB. 13 1 M 2 XF Hours Min 577-38-8382 80 MARYLAND Director 1931 Usual Residence of Decedent show 10b. County 10d. Inside City Limits at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 □ No PRINCE GEORGE'S MDUPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3802 SADDLEBROOK COURT 20772 USA ral", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) il Mental Hygiene. marked other than "I matic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE TEACHER AIDE 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even ပ JOHN BROWN HARTRELL M. HOLMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL A. DUNCAN-WOODLAND/DGT. 3802 SADDLEBROOK COURT UPPER MARLBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State FT. LINCOLN CEMETERY: 7/9/2011 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signatur of Fundal Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PARKINSON DISEASE ADVANCED disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 ☐ Yes 2 X No 2 X No 1 Yes after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) bowie Healtn Enecify Center Hospital Other: 2 🕱 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work? 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Prac the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) D43351 JULY 5, 2011

5 gm

State Registrar

DHMH 17 Rev 7/2009

2200 ANNAPOLIS ROAD # 316 GLENN DALE, MARYLAND 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKWARA

F.

Days

Months

10f. Zip Code

16a. Decedent's Usual Occupation

life. DO NOT use retired)

HOUSEWIFE

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY CEMETERY

20737

1 ☐ Yes 2X No Specify.

22. Name and Address of Facility

(Give kind of work done during most of working

7. Age (In yrs. last birthday)

10c. City, Town or Location

RIVERDALE

82

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 🛣 No

College (1-4 or 5+)

Removal from State

if Yes, Give Year or Dates

HYATTSVILLE If Under 1 Year If Under 24 Hrs

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Min.

8. Date of Birth

18. Mother's Name (First, Middle, Maiden Surname)

CALLIE KORNECAY

7/14/2011

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5208 WILEY STREET RIVERDALE, MARYLAND

1929

USA

10g. Citizen of What Country?

16b. Kind of Business Industry

PRIVATE

20c. Location - City or Town, State

J. B. JENKINS FUNERAL HOME, INC.

LANDOVER, MARYLAND

Specify:

14. Race - American Indian

BLACK

Black, White, etc.

9. Birthplace (State or Foreign

10d. Inside City Limits

Yes 2 No

NEW JERSEY

Medical **Examiner Funeral Director** ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at the Maryland 72 hours after death with Baltimore, Maryland 21215-0036 nit. Page 1 and 2 should be filed wit artment of Health and Mental Hygie ortant. If item 27 is marked other injury or other traumatic event, th

Physician/

Director

Funeral

2

Completed

Be

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For State Registrar

238-36-5976

10e. Street and Number

11. Marital Status

Usual Residence of Decedent

6710 PARKWOOD STREET

10b. County

6608 GREENLAND STREET

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Seconday (0-12)

12th

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

JAMES E. WILSON

1 Burtal 2 Cremation

19a. Informant's Name/Relationship (Type, Print)

HILDA SMITH/SISTER

Donation 5 ☐ Other (Specify)

Signature of Fun Serve Licensee

1 🗆 M 2 🗶 F

PRINCE GEORGE'S

15. Decedent's Education

(Specify only highest grade completed)

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

주트 뿐 일		1 (/2	~ u	7474 LANDOVER ROA	D HYATTSVI	LLE, MARYLAND 20785					
ysician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	CARDIOPULMONARY ARREST							
aminer	edical Examiner	Sequentially list conditions, if any, leading to infinite uate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. ASPIRATION PNE Due to (or as a consequence of). C. DYSPHAGIA Due to (or as a consequence of):	ASPIRATION PNEUMONITIS Due to (or as a consequence of): BILATERAL CEREBRAL VASCULAR ACCIDENT							
the attending posterior	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 丛No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year						
with the Fundal backer that the this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute									
cate,		TYPE II DIABE	TES MELLITUS		performed						
is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one) Hospital: 1								
or: After th	Certificate:	27. Manner of Death 1 ▼ Natural 5 □ Pending 2 □ Accident Investigat 3 □ Suicide 6 □ Could no		ne of 28c. Injury at		d. Describe how injury occurred					
al Direct		4 Homicide determine		, street, factory, office		Bf. Location (Street and Number or Rural Route Number, City or Town, State)					
he Funer	Medical	(Check 2 Medical Exa	hysician: To the best of my knowledge, de iminer: On the basis of examination and/or ir urse Practioner: To the best of my knowled	nvestigation, in my opinion, death occurred	at the time, date and pl	ace, and due to the cause(s) and manner s					
		29b. Signature and title of certifier MD 29c. License number D32654 29d. Date signed (Month)									
108		30. Name and addless of person who	o completed cause of death (Item 23a) (Typ	pe, Print)							

23d. Date of delivery Month Dav Year so use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 🕱 No No ASSIT. LIVING 6 AOther (Specify) jury occurred and Number or Rural Route Number, ate) and manner as stated. ace, and due to the cause(s) and manner stated. se(s) and manner as stated. Date signed (Month, Day, Year) ULY 11, 2011 JOHN P. SERLEMITSOS M.D. 2033 PENDERBROOK DRIVE CROWNSVILLE, MARYLAND 21032 2. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Marylar		artment of He tificate of De			ZUI	1 22028		
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of De	aui	2. Date of Death	eg. No.	3. Time of Death		
	Physicia		Lynn A.	Bearma	n		\mathbf{July}^{Month}	6, 20	Year		
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Death			
1			Johns Hopkins Bayview Medical			more Cit			/A		
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🔀 F 65	last birthday) Yrs.	If Under 1 Year I: Months Days I	Hours Min.	8. Date of Birth (Month, Day, Nov. 16,	Year) 1945	9. Birthplace (State or Foreign Country) Maryland		
	d t t	L	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Lo	ation				10d. Inside City Limits		
	arylan a-f sh fied a	Director	MD Baltimore	ty, fowir of Loc		gemere			1 ☐ Yes 2 🏝 No		
	or 28 or 28 e noti	Dir	10e. Street and Number		10f. Zip Code	Cincre	10	Dg. Citizen of W	hat Country?		
	s 23a ust b	Funeral	2924 Delmar Avenue		21219			United	States		
	death item nerm		11. Marital Status 12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto l	cify Yes or No- Rican, etc.)		- American Indian, , White, etc.		
036	s after al", or Exami	Completed by	1 ☐ Never Married 2X Married 1 ☐ Yes 2 1 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	1	☐ Yes 2 No	Specify:		Specify:	White		
2-0	hour hatur dical	plete	15. Decedent's Education (Specify only highest grade completed)	16a, Deced	lent's Usual Occupation	on ina most of worki	na .	16b. Kind of Bus	siness Industry		
2	hin 72 ne. than '	omi	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	NOT use retired) Homemake		'g	Own	Home		
0 0	ed wit Hygie other ent, th	Be C	12 Years 17. Father's Name (First, Middle, Last)			8. Mother's Name	(First, Middle, M	-	I.O.I.C		
/lan	d be fill Aental Arked o	ြ	Harry Pence				e Hudak				
, Maryland 21215-0036	d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Charles E. Bearman (Husband)	19b. Mailir 292	ig Address (Street and 4 Delmar /	Number or Rura Avenue	Route Number, 6 Edgemere	City or Town, Sta Mary I	and 21219		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I frem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		l - 3	acmetani oran	sition (Name of natory or other place) ervice Col	i -			City or Town, State Maryland		
Balt	permit. Departr Imports any injt		21. Signatul of Funeral Service Licensee	22	Name and Address of Duda-Ruck 7922 Wise	Funeral Ave. Dur	Home of	Dundal aryland	k, Inc. 21222		
			23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart fallure. List only one cause on each line.	th. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arres	st,	Approximate Interval Between		
P	h _{sici} n Medical			ETASTA	ne lous	N CANO	en		Onset and Death		
	Examiner		Due to (or as a conseq	uence oī):							
1	e ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a conseq	uence of):							
Box 68760	ate be executed obysician and the burial-transit	Exan	Cause (Uisease or iinjury that initiated events c. resulting in death) Last Due to (or as a conseq	uence of):							
09	s be ey ysiciar e buria	dical	d								
6876	ng phy as th	Med	IF FEMALE:				- 1				
Box 6	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year		
Ö.	y the a	hysic	1 Yes 2 No 4 Pregnant at time of 9 Unknown	death 5 L	Other (specify)						
P.O	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause given	in Part I.			oute to the cause of death?		
rds	equire seen si hould I	eted							3 Probably 4 Unknown		
Division of Vital Records,	to the Pospital of Attending Prysician. The law requires that the within 24 hours and the within 24 hours and the forest of additionable that this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed					24a. Was an autops perform	y pi ned? de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No		
ta .	ertifica ector, p	Be	25. Was case referred to medical examiner?	,		e of Death (Check					
<u> </u>	rnyst this o	2	1 Yes 2 No 1 Inpatient 2 27. Manney of Death 28a. Date of injury	ER/Outpatier 28b. Time of			me 5 Reside				
0 00	ath. :: After e funer	cate	1	injury	work?	s 2 🗆 No	zod. Describe nov	w injury occurred			
VISIO	r Atter ter deg irector ir by th	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At h building, etc. (Specif		eet, factory, office		28f. Location (Str City or Town,		or Rural Route Number,		
	pural o		29a, Certifier 1 Certifying Physician: To the best of my know	vledge death	accured at the time d	ate and place, an	d due to the caus	e(s) and manne	r as stated.		
	to the nospital of Attending Prysician: which not hours after death. To the Inneral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of medical Examiner:	on and/or inves	tigation, in my opinion,	death occurred at	the time, date and	d place, and due	to the cause(s) and manner stated.		
	with To t		29b. Signature and title of certifier		29c. License n	umber	29	9d. Date signed	(Month, Day, Year)		
	6		30. Name and address of person who completed cause of death (Iter	m 22a) /Time - F	MD Mint	1199001	07	July	7, 2011		
	り		Name and address of person who completed cause of death (Iter	n 23a) (Type, F 2 2	D101061	S174 6	Ball.	uno m	per 2:201		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signa			···········		,			
	Registra	ell	JUL 1 2 2011 /2	Reshed							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bell Elvera : 10 PM JULY 7 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown North West Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Apr 30, 1 M 2 X F South Carolina ¶960 Director 51 218-78-8127 Usual Residence of Decedent show Hygiene. other than "natural", or items 23a or 28a-f shov rent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral filed within 72 hours after death with 21211 United States 3522 Greenspring Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic event, the once. h and Mental Hygien 11 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ James Hardy Bell Shirley Temple Snow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4303 West Forest Park Ave Baltimore, MD 21207 Shawntay Bell / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 7/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 wox MO1251 23a' Part 1. Enter the esease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cervial cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☑ Unknown Hospital or Attending Physician: The law requires that the death Year Month Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has performed. Yes 2 ✓ No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 4 - Nursing Home 5 - Residence 6 Wother (Specify) Hospital 2 🖪 No မြ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Ms Rijapahem.D DO 057465 38M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MA N.S. Rajapaksemo 2835 Smith AV S-203

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 Francisco J. Bravo ĭŎ. 4:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 2408 Marbourne Avenue Apt 2D Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Month, Day, . 1<u>945</u> 1 **X** M 2 □ F Hours Min Nicaragua 66 Yrs. Director 071-72-9629 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director · 28a-f 1X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or Funeral USA 2408 Marbourne Avenue Apt.2D 21230 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 X Yes 2 □ No Specify: Nicaraguan Specify: Hispanic Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Merchant Marines Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file I and Mental H Is marked ot မ of Health and Menta fitem 27 is marked rother traumatic ev Juanita Hernandez Jose Bravo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Marbourne Avenue Apt.2D Baltimore, MD 21230 Aileen Bravo, Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 07/11/11 Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one calls on each line. Interval Between Onset and Death Immediate Cause (Final Bcell fuse Physician/ Recurrent disease or condition Medical resulting in death) months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Certificate: To Be Completed by Physician/Medical Examiner Due to for as a consequence of, or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral 27, Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital of thin 24 hours at the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0069300 MIAN KHALID MD

State Registrar JUL 1 2 2011

KWWID, 7141 SECURITY BLVD, BALTIMORE,

32. Registrar Signatural Signatural Security BLVD, BALTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #26 Per PHY G917 //12/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No: . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J_{u}^{Month} Physician/ $3,20^{13}$ 11:34P Emma V. Bigham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 5910 Marluth Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Min. (Month, Day, August Maryland Director .191B 212-01-2654 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No N/A Md. **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Completed by Funeral 21206 USA 5910 Marluth Avenue Page 1 and 2 should be filed within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc ☐ Yes 2**X** No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Specify 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. Assembly Bendix Radio 8th t of Health and Mental Hyg If item 27 is marked othe or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Florence Rebecca Baker Franklin Ash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ann Stevenson DTR. 1301 Vermont Road BelAir, Md. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Department o Important: If any injury or once, ō 7-7-2011 Gardens of Faith Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuheral Service Licer 22. Name and Address of Facility -Henss-Seitz alls Road B 21211 Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oratory Medical onsequence of Examiner Sequentially list ponditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying onsequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last attending physician for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown ed by the detached Division of Vital Records, P.O. After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ■Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 N 1 Yes 2 No 25. Was case referred to medica examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 4 Nursing Home XX Residence 6 Other (Specify) 2 V No 2 1 🗌 Yes 1 Inpatient 2 Inpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suiciae 4 ☐ Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Ny'se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and little of re 29d. Date signed (Month, Day, Year) 0 Millineaus mawn 31. Date filed (Mont JUL 12 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bonth 7 Physician/ 5:25 AM MARJORIE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Manor Care-Potomac 8. Date of Birth (Month, Day, Year) May 22, 1927 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Months Days Washington, D.C. 579-30-1075 84 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Markinal Examples. 10c. City, Town or Location 10b. County Director 1 Tes 2 No Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20817 Funeral 9905 Inglemere Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Barber John Poole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9905 Inglemere Drive, Bethesda, Maryland George Bisset/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. Rock Creek Cemetery Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Dementia Advanced Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner malnutrition quentially list nondhions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury cute Renal Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Kranes Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Day in the past 12 months? Month Year Pregnant at time of death ate has been signed by the page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057458 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pinky Singh, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814 Pinky Singh, M.D. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 07 Month 3. Time of Death Physician/ 05^{Day} 20^{rear} 3:30 P M BROOKS VERONICA С. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 706 GLENWOOD AVE. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Min Country) Director 212-44-8197 68 0 - 18 - 194Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1X☐ Yes 2 ☐ No BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21212 U.S.A. 706 GLENWOOD AVE. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed BLACK the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FINANCE ACCOUNTANT other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F မ UNKNOWN ELSIE BROOKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21212 706 GLENWOOD AVE. BALTIMORE, SHEKIA EDWARDS/GRANDAUGHTER 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ò 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or KING MEMORIAL PARK 07-12-2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) e of Fun al Service I 22. Name and Address of Facility WILLIAM CORTH AVE. BALTIMORE, MD 21217 P.A. Vart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ thero sclerutic disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner ert Sequentially list conditions Examine to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dué or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 🗷 No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) eral Director: After th filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural Natural 1 Yes 2 No M Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours To the Funeral I Hospital Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, motur Hl 2011 Juli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21217 HIN STREET.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:20 F M 701 Elizabeth Arlene Burke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meredith Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 16, 1933 1 M 2 X F Months Massachusetts Director 002-22-4576 77 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20015 Cherry Hill Cir 21742 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mildred Wilamena Griffith Clarence D. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Gregory C. Burke - son 21342 Mt. Lena Rd; Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) cemetery, crematory or other place) Signature of Juneal Service Mcen Naylor 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Medical ue to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or se a consequence of Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 L relation.

Pregnant at time of death Live Birth 2 Fetal death in the past 12 months? Month Day Year Yes 2 No Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician; The 2 No 1 🗌 Yes of Vital 25. Was case referred to 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 - No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Division 24 hours after death, Funeral Director: A 1 Tes 2 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jefferson BUD MIMSTUR 1 2 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 2011 12:40P. M David George Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 6. Sex 1 M 2 D If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours July 7,1958 216-70-3800 53 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Directo 1 🗌 Yes 2 💢 No Anne Arundel Maryland Riva 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 101 Remital Road 21140 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Boating Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Edward Brown Rhea Gertrude Hagelin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8193 Brandon Drive, Millersville, Maryland Megan A. Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ardent Cremation, Inc. 7-11-11 Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mrzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee
Puchaul I. Man 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tract sepsis Physician/ UNINOV7 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Day Year Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ acidosis 2 No 3 Probably 4 Unknown Division of Vital Records, Certificate: To Be Completed huer disease Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? poneventitio 1 ☐ Yes 2 ☐ No this certificate I or Attending Physician: after death.
Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

1 2 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	-	epartm <i>Certifica</i>			d Me		jiene		22036	
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<u>a</u>	2 shoth ar th ar 27 is trau		19a. Informant's Name/Relationship (Type Donald J. Bufano	s, Print) Son		Mailing Addr 004 Pi	'				city or Town, e, Mary		^{Code)} 21209	
œ,	of Heal of Heal fitem 2		20a. Method of Disposition		20b. Place of	Disposition (f	lame of		Date	T	20c. Location			
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Box 68	certific	Jue M	IF FEMALE: 23b. Was decedent pregnant in the post 13 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy									23d. Date of delivery		
. Box	law requires that the death certific nas been signed by the attending t s 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tir		5 Other		y 			Month Day Year			
Division of Vital Records, P.O.	sician: The law requires that the de. certificate has been signed by the . rector, page 2 should be detached	by	Part II. Other significant conditions conf	ributing to death but r	not resulting in	the underlying	ng cause give	en in Part I.					ne cause of death?	
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Jivisi	al or Atte s after de I Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S		n, street, fact	ory, office		28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of exan	nination and/or	investigation,	in my opinio	n, death occurr	red at the	time, date an	d place, and du	e to the ca	use(s) and manner stated.	
	To the Comp		29b. Signature and title of certifier				9c. License	nse number 29d. Date signed (Month, Day, Yea					Day, Year)	
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/			30. Name and address of berson who con	npieted cause of deat	n (Item 23a) (T) Thee R	/pe, Print)	35 Bo	altimo	re M	langlan	8 2120	28		
Ė	Stat Registra	ie ar	31. Date filed (Month, Day, Year) JUL 12 201	npleted cause of death 38 Greene 38 Registrar's	Signature	parke	/							

amend \$2,4a 226 or Perint in Black Indelible link. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death July 8,2011 3. Time of Death Physician/ Brettschneider laine 0234 AM Medical University of Whedical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death TOCK I going Baltimore Center N/AIf Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2X F Months Days Hours (Month Day Year) 04/07/1931 **Director** 212-34-4505 80 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2449 TUFTON AVENUE 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **EMANUEL** YOSPY IDA SCHOFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID M. BRETTSCHNEIDER/HUSBAND 2449 TUFTON AVENUE, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CARROLL CREMATION INC: 07/11/2011 HAMPSTEAD, MD ature of Fuheral Service Lice 21. Sg 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mall 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Subd disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Duvi to for as a nonsectioned or cause. Enter Underlying Cause (Disease or iinjury Examir and that initiated events resulting in death) Last Due to (or as a consequence of): -burial-1 physician the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 1 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🗆 No Other: မ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural Accident 5 Pending July 07,2011 Investigation Could not be ta /1 Unknown Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2449 Tufta, Ave, 21136 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe D66267 29d. Date signed (Month, Day, Year) 08,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene Street Baltimore, MD 31. Date filed (Month, Day, Year)

JUL 12 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1048 PM Doris Clear Medical 4a Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth tel Inne Howers 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 01/13/1933 Country) Director MD unkr Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 1996 Carrollton Road 21048 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 Widowed 4 K Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) US Postal Service Letter Carrier Be 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Landis Maryland 17. Father's Name (First, Middle, Last) William ည Kirkner 19a. Informant's Name/Relationship (Type, Print)
Nicholas Clear / Son 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
1016 Pacific Avenue, Alameda, CA 94501 Itimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey crem. 7/13/2011 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 2 21. Signature of Funeral Service Licensee Dorota Marshall Bal Sha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? bestructure Pulmanous 24a. Was an autopsy this certificate has page 2 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 \quad Yes 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After injury 1 Natural 5 Pending Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** CAPUTO MARY 5:450 M 10 2011 JUL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chapel Hill Nursing Home Randallstown Baltimore Social Security Number 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
PA 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 👿 Months Days Hours 106-22-4459 Director 80 July 20, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Director MD Carrol1 Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or item 27 is marked other than "natural", or items 23a or item pay injury or other traumatic event, the Madical Eventual rust but once. 5375 Thames Court 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White ð Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Caliguri Marie Cipolla မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Steve Caputo (Son) 13 Redwood Court, Monroe Twp., NJ 08831 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Charles Cemetery 7/25/2011 Pinelawn, NY 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee Hugy PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE CARDIOTYOPATIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) ⁹ Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property of the physician and precious after this certificate has been signed by the attending physician and certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of deeth 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☑No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 🖼 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

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Registrar

31. Date filed (Month, Day, Year)
JUL 1 2 2011

29b. Signature and title of certifier

one

OLD COURT ROAD # 201 RANDALLSTOUN 510 21135 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. S. RAS. F.O.

29c. License number

D43462

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZELMA 3.00 PM 2011 luhu Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Baltimore County 4b. City, Town, or Location of Death **Examiner** Baltimore Augsburg Lutheran Home Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 **X** F March 1925 North Carolina Months Days Hours 218-22-4257 **Director** 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~ ^ 0 ~ c any injury or other traumatic event; the Madizal. 10d. Inside City Limits 10c. City, Town or Location Director Baltimore County Lutherville 1 🗆 Yes 2 🖺 No Maryland 10e Street and Number 10f. Zip Code Citizen of What Country?
United States 21093 Funeral 12 Alston Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Contract Clerk Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) USFG Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Minda Frances Upchurch John Calvin Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Alston Court Lutherville, Maryland 21093 Mr. Steven Rothschild (Friend) 12 Alston Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State County) 1 🚰 Burial 2 🗆 Cremation 3 🗆 Removal from State Dularey Valley Men. Gardens 4 ☐ Donation 5 ☐ Other (Specify) July 15,2011 Timonium, Maryland Signature of Funeral Service License Jeffrey L. Gair, St. CFP 2. Name and Address of Facility Less Funeral and Cremation Center, P.A. Tencenul Alternatives Funeral and Cremation Center, P.A. 2003, 2015 Lic.#M00677 your in 21093-2215 2325 York Road Timonium, Maryland 23a. Part 1. Bhtsythe disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for Pregnant at time of death Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available LZHEIM EX 24a. Was an prior to completion of cause of death? performed 2 1 No 1 Yes 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 3 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral I Medical The Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

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completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my browledge, death occurred at the time. Sate and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier ellelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 MI 1/61

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 100 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ Month JUL Pay 8. Zear 11 6:35F M William Roger Corliss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Haltimore **Examiner** Saint Joseph Medical Towson Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Year 1926 Month, Aug 28 Connecticut 040-22-0120 84 Yrs. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at Director notified 1 ☐ Yes 2X No Baltimore Glen Arm Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be 23a Funeral 21057 11604 Manor Road USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner was Decedent Ever in U.S.

Armed Forces?

1944
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Ь Completed by Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ the Self Employed Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Hazel May Brown George Martin Corliss traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Glen Arm, Maryland 21057 11604 Manor Road Virginia Corliss, Wife altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 07/11/11 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory Inc. Signature of Funeral Service Green Thomas Gregor Cremation Society Of Maryland, inc. 299 Frederick Road Baltimore, Maryland 21228 Mmar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed seen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? e Hospital or Attending Physician: The law 1 24 hours after death. • Funeral Director: After this certificate has b page 2 autopsy performed' 2 No Yes 2 N 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-8-2011 D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE TOWSON, MARYLAND OSLER Registrar's Signa State Registrar

DHMH 17 Rev 7/2009

11-05066	
Mary Costello	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

22042 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Month D July 7, 2011 Day Medical Examiner Mary Carol Costello 1229 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3128 Eden Drive Abingdon Harford 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)Maryland 214-98-4132 Months Days Hours Min. Director 46 1 M 2 X F 10/29/1964 Yrs Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once, 1 Yes 2 No Maryland Harford Abingdon Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3128 Eden Drive 21009 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes 3 Widowed Yes, Give Year 4 Divorced 1 Yes 2 No specify: White other than "natural", Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Receptionist Medical Field 17. Father's Name (First, Middle, Lest) 18.Mother's Name (First, Middle, Maiden Surname) Michael Morrow Costello Mary Macatee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Costello / Brother 3115 Cool Branch Rd., Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore. 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory Inc. 07/11/2011 Baltimore, Maryland 4 Donation 5 Other Specify 22. Name end Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service LicenseeAlyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 ai 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Hanging Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): ne if eny, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit : Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical for use as the burial UNPENDED AMENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnent at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been single, page 2 should b 24a. Was en 24b. Were autopsy findings available autopsy prior to completion of cause of death? perform certificate Yes 2 ✔ No 1 Yes 2 No After this certific funeral director, I 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject hanged self 1 Natural FOUND: Pending 1 Yes 2 ✔ No hours a er death the Funeral Director: npletely filled in by the Jul 7, 2011 1225 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3128 Eden Drive , Abingdon, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 9, 2011 ELIZABETH ELEANOR CURRIE 9:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD 11086 WINEGLASS CT **COLUMBIA** 6. Sex 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 XX Months Hours AUG 30, Day 929 016.22.9237 81 Yrs. Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes XX No MD HOWARD COLUMBIA 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 11086 WINEGLASS CT. 21044 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any riginry or other traumatic event, the Medical Examirane. þ 1 Never Married 2 XX Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes XX No Specify. 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 NURSE **HEALTHCARE** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ THEODORE P. JONES **ELEANOR 1. CURTIS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD A. CURRIE 11086 WINEGLASS CT. COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 XX Removal from State cemetery, crematory or other place) July 11,2011 **GLENWOOD CEMETERY** 4 Donation 5 Other (Specify) MAYNARD, MA f Funeral Service L 22 Name and Address of Facility P.A. t/a MARYLAND MORTUARY SUPPORT CREÇORY FIN 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 23a. Part 1. Enter the dis mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest rone cause on each line. Approximate shock, or heart Interval Between Onset and Death Immediate Cause (Final Phylician Schemi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, thank eaching to him medicause. Enter Underlying Cause (Disease or iinjury Dies to for as a consequence of Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death d be detached t detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{ Other (Specify)} 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Vithin 2 3 only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) 1 2 2011

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Registrar's Signature

Fernando C. Cor	nmo				f Maryla					ensure alth and				gibi			
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Bruno Co	mmodar	i_		В	ro.	32	17 W	oodsi	de Av	enue	e Pa			_	21234
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(Check only one) 2 ✓	Medical Exa	miner:		of examin											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 2011 a M David Davis 1:43 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pittston Circle Baltimore Owings Mills Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7-28-1948 1**XX**M 2 □ F Director 226-70-3180 62 MD Usual Residence of Decedent 28a-f shov 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No MD Baltimore Owings Mills ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r United States 21117 Pittston Circle ural", or items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. "natural" Specify: White Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Bartender 15 Miles House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Elza Davis Ruth Bu11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 Pittston Circle Owings Mills, MD 21117 Carey Davis (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal fro cemetery, crematory or other place, ation 5 Other (Specify) Carroll Cremation, Inc. 7-8-2011 Hampstead, MD 22. Name and Address of Facility ELINE FUNERAL HOME MD 21136 Wayne Osterling 11824 Reisterstown Rd. Reisterstown, the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest part (ailure. List only one cause on each line. 23a. Part 1. Ente shock, or hea Immediate Cause (Fina disease or condition Onset and Death Ph, sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an After this certificate has funeral director, page 2: performed? Yes 2 No completed filled in by the funeral director, 25. Was case referred to predica 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar CEnter St. Westminster, MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 S.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Physician/ Mont : 45 A M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 46. City, Town, or Location of Death N/A (en rsing 5. Social Security Number 7. Age (In yrs. ast birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Months Hours Director Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 No Maryland Howard North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20878 12641 Lloydminster Drive Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic approx. Elementary/Seconday (0-12) College (1-4 or 5+) Kitchen Cabinet Distributer Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Katherine Kelly Richard J. Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12641 Lloydminster Drive North Potomac, MD 20878 Mary Kathleen McCaughey - Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Baltimore National Cemetery 07-14-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility 5305 Harrford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death nly 9 Immediate Cause (Final Fnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical nurexia P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🚺 No 5 Other (specify) Month Pregnant at time of death Day Year 4 ☐ Pregnant g ☐ Unknown 1 ☐ Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, noun 2 No 1 Yes 3 Probably 4 Unknown 21118 disord 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 📝 No death? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of dealer (Item 23a) (Type, Print) im 32 timiure. O venue enson 31. Date filled (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James J. DeCosmo July 10. 6:30 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3309 Woodring Avenue Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-22-5319 Days 1 X M 2 D F Months Min. Hours June^{nt}29^{ay,} 1930 Mary Land Yrs **Director** Usual Residence of Decede 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Examiner must be notified N/A Baltimore Maryland 1X Yes 2 ☐ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3309 Woodring Avenue 21206 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc o, þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic execution. Elementary/Seconday (0-12) College (1-4 or 5+) Crane Operator Bethlehem Steel 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Victoria M. Kaniecki Joseph Vincent DeCosmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3309 Woodring Avenue Baltimore Maryland 24206 21234 Angelina DeCosmo/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Baltimore Maryland 4 Donation 5 Other (Specify) 07/13/2011 5305 Harford Road Signature of Funeral Service License Name and Address of Facility Leonard J. Ruck, Inc. Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si i n disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death be detached 9 Unknown g 🗌 Unknown Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 🗌 No Yes hours after death.

Ineral Director: After this certific

filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Hatural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours and To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of dertifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 01 (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 2 1 8

		1- For State Registrar			Certific	ate of L	Death			, C	eg. No.	J 1 6	Summa Server Stand 2 Ser
Physicia		Decedent's Name (First, Midd			-					2. Date of Dea Month	ith	'ear	3. Time of Death
Medical Exami	ner	Karen L. Dix	ton							July 5, 20	11		0915 hrs
		4a. Facility Name (if not institution, give street and number) 200 Frank St. Apt A Snow Hill									4c. Count	y of Death Ster	1
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last bin	thday)	If Under 1 Ye		er 24Hrs.	8. Date of Bi	rth(MM/DD/YY	YY) 9. Bir	thplace (State or
Director		Unk 210-42-0681	1 M 2XF		5	8 Yrs.	Months Da	ys Hours	s Min.	Dec 1	8, 1952	2 Co	m Wèst ^{puntry)} Virginia
And A		Usual Residence of Decedent 10a. State 10b. County		I10c (City Town	or Location							
				100.									10d. Inside City Limits 1 Yes 2 No
urylan Sa-f sk	cto	Maryland Word 10e. Street and Number	ester		Sn	ow Hi	L L Of. Zip Code				0g. Citizen of	Mhat Cou	
0036 within 72 hours after death with the Maryland giene. ber than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	I Director	200 Ironshire	Street A	pt. A.				863			USA		nu y r
th wit	Funeral	11. Marital Status 1 Never Married 2 M		cedent Ever i orces?	n U.S.	13. Was [If Yes.	ecedent of H specify Cuba	ispanic Ori	gin? (Sp	ecify Yes or No		ce - Amer	ican Indian, 8lack,
er dez			1 Yes	2 💢 N	0		es 2 X N			, , ,			L -
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5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)					of working lif				Too. rang of	Businics of	industry
ithin ene.	립	12				Re	ealtor				Real I	Estat	e
Hygi		17. Father's Name (First, Middle			-			18.Mother	r's Name	(First, Middle, I	Maiden Surnan	ne)	
21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be	Thomas L. Dix 19a. Informant's Name/Relations			Lin					ine Bre			
MD 2 12 shou th and N 127 is n	욘	Maxine A. Ande		hor	T					ural Route Nur			
_ = 7 7 5 2		20a. Method of Disposition		20	b. Place o	of Dispositio	n (Name of c		L INW	Albuqu Date	20c. Locatio		
nor ages l ages l nt of l other	П	1 Burial 2 X Cremation				ory or other		Г	07/	11 /11	D-1+4	· !	Managaran
Baltimore, permit. Pages 1 a Department of He Important: If it in injury or other the	ŀ	4 Donation 5 Other S/21. Signature of Funeral Service	Licensee Thom	oo Cro	etro	22. Nam	atory	s of Facility	V V V	11/11	Dart.	шоге	, Maryland
		Thomas &	Turall	as Gle	gor	Crer	nation Frede	Socie	ety (Road	Of Mary Baltim	land,	Inc.	nd 21228
Physician		 Part I. Enter the disease, or failure. List only one cause 	complications that c	aused the de	ath. Do no	ot enter the	node of dying	, such as c	ardiac or	respiratory err	est, shock, or h	neart	Approximate Interval
/Medical Examiner	ļ	Immediate Cause (Final disease		alcoh	nol a	buse							Between Onset and Death
		or condition resulting in death)	Due to (or as a	consequenc	e of):								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequenc	e of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С										
scuted and transit		events resulting in death) Last	Due to (or as a	consequenc	e or):								
al al	/Medical	X UNPENDED	X AMENDED	5,23a,	27,p	er me,	g918 8	3-1-11	sm				
3760, ficate be g physicist the buri	Ě	IF FEMALE:		outcome of p	regnancy	-					23d. Date	of delivery	<u> </u>
68 certifi nding se as t	ä	23b. Was decedent pregnant in the past 12 months?	I TIVE D	irth ant at time of	2	=	death 3	Ectopic	pregnar	ncy	Month		Day Year
Box 687 re death certific the attending pred for use as the	Physiciar	1 Yes 2 No 9 V Unk	known 9 Unkno		death 5	Other	(Specify)						
P.O. I		Part II. Other significant condit	ions contributing to	death but no	ot resulting	in the unde	orlying cause	given in Pa	art I.	23e. Did to	bacco use cor	tribute to	the cause of death?
ires that signed	ğ Ş									1 Yes	2 No :	3 Prob	pably 4 🗹 Unknown
w requir	Completed									24a. Was autop			topsy findings available completion of cause of
Pecc The lar ate ha	Ē										med?	death? 1 ✓ Ye	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical			7/31		26.Plac	e of Death	(Check or		2 110	· 💆 ie	2 140
'Vit	인	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir	npatient 2	ER/Ou	tpatient 3	DOA	Other ₄	Nursing	Home 5	Residence 6	✓ Other	: Scene
ding Pt	ᇙ	27. Manner of Death 1 X Natural 5 Road		of Injury , Day,Year)	28b. T	ime of Injur	' '	iry at Work	- 1	28d. Describe h	now injury occu	rred	
SiOr Attended death death ctor:	<u>ğ</u>	rend	stigation					Yes 2					
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be a proper at the funeral director, page 2 should be a should be	Certification:	deter	d not be 28e. Place mined (Specify)	e of Injury - A	t home, fa	rm, street, fa	actory, office I	building, etc	c. 2	28f. Location (S or Town, S		ber or Ru	ral Route Number, City
Tospit funera		4 Homicide	(0,000,7)	t of my knowl		41	-140		1/				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Check only one) 2 Medical Exar	hysician: To the best miner:On the basis o and manner st	of examination	n and/or in	vestigation,	in my opinior	ate and pia n, death occ	curred at	the time, date	e(s) and mann and place, and	er as state due to the	ed. e cause(s)
F FF 3	ž	29b. Signature and title of certifie		orog.		·	29c. Licens	se number			29d. Date sig	ned (Mor	nth, Day, Year)
		total (Ino	n +60	lun .	>		O.C.	M.E.			July 6, 20	11	
Le St	Ī	30. Name and address of person											
84		Patricia Aronica-Pollak				iner 90	0 W. Baltii	more Str	eet, Ba	altimore, MI	D 21223		
Sta Registr	_	31. Date filed (Month, Day, Year) JUL 12		gistrar's Sign	ature	600							
DHMH 17 Rev 1/200		***	···· CEMM	m /	A.	GINAL	<u> </u>						
OCME 2006					~ · · · · · ·								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARR be Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death Examiner TI MORE If Under 24 Hrs. Hours Min. 8. Date of Birth (Modith, Day, . Age (in yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**∭** M 2 □ F Months Director Usual Residence of Deceder 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 No DC Keys 10f. Zip/Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral 1030 items 23a ISA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Completed by 1 Never Married 2 Married 2 No 1 Yes 2 No Specify Specify Whit 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4/or 5+) pration Be 18. Mother's Name (First, Middle, Maiden Surdame) 17. Father's Name (First, Middle, Last) ဂ္ City or Town, State, Zip Code), 19a. Informant's Name/Relation ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, cremator 4 ☐ Donation 5 ☐ Other (Specify) rores RD. MONKTON ND ZILLI 21. Signature of Funeral Service Licenses 24 YOR Remotion SERVICES emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List or Approximate Interval Between Onset a, d Deall Immediate Cause (Final cerebiovasculas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after dearn.

To the Funeral Director: After this certificate becompleted filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at iniury 1 Natural 5 Pending work?
1 ☐ Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 913 CYRUS 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SHMK Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice Randallstown Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1 M 2 □ F 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Country Tennessee Feb. 10 Days 196-28-4614 1937 74 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 2802 Delmont Avenue 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify Specify: 3 M Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Roofing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Onnie Dishman Faye Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Letita Avenue, Baltimore, Maryland 21230 Lisa Hudgins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation, Inc. 7-2-11 Hanover, Maryland Ardent 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 21. Signature of Funeral Service Licensee michael Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequenc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was a autopsy performer 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of ce

State Registrar

31. Date filed (Month, Day, Year,

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July ^{Day} 2011 7 12:33 P CAROLYN E. DEEMS Medical Town, or Location of Death ${f Towson}$ 4a. Facility Name (if not institution, give street and number) Greater Baltimore Medical Cente Examiner 4c County of Death Baltimore 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 \square M 2 215-16-2422 89 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 ☐ Yes 2 🎇 No TOWSON MD BALTIMORE 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be n Funeral 536 PICCADILLY ROAD 21204 USA ural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If Yes, Give Year or Dates 1 Yes 2 XNo Specify "natural", Specify: WHITE Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) **12TH GRADE** College (1-4 or 5+) SECRETARY MCCORMICK CO. event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ HARRY C. BIRELY KATHRYN T. MCKELVEY Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SR./BROTHER TOWSON, 21286 ROBERT K. BIRELY, 8505 DRUMWOOD RD. MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 7/11/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, TOWSON, 21286 RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran and attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death should be detached the signed by Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending Natural work? 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

State Registrar 30. Name and address of person

2 2011

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2011 Robert E. Eburg, Sr. July 08 Medical 8:45P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Days Hours May 04, Year) 87 217-18-8392 **Director** Hampstead, Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director Maryland **Baltimore** 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3408 E. Northern Pkwy 21206 United States items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò \$ 1 Never Married 2 Married Maryland 21215-0036 WUI 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural" Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Service Manager Dulaney Motors other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles E. Eburg Blanche Frush and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Catherine Eburg (Spouse) 3408 E. Northern Pkwy Hamilton, Maryland 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 11,2011 20c. Location - City or Town, State Page 1 cemetery, crematory or other place)
Evans Funeral Chapel-Bel injury or 1 Burial 2 X Cremation 3 Removal from State Department or Important: If any injury or once, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Cremation

8800 Harford Road Parkville, Marganet Shock, or heart failure. List only one cause on each line.

Immediate Cause (Fixed disease or condition resulting in death)

a. Due to (or as a consequence of): 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland Interval Between Onset and Death Physician/ Medical Examiner Sequentially list conditions. Dusito for as a consecuence of: cause. Enter Underlying Exam burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by CARUTIO STONOSIS Records, 1 Yes 2 No 3 Probably 4 Unknown PERIPHORAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy After this certificate 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICO 1 ☐ Yes 2 ☐ No Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural inlury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)

Marie Alice Elliott 2. Date of Death 3. Time of Death Physician/ 07. Day 2011 Year July 7:36 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Timonium** 4c. County of Death

Baltimore County Examiner Stella Maris 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 D M 2 F Months Days Hours 219-07-4713 93 Aug. 06, 1917 Maryland Director Usual Residence of Decedent 28a-f shov 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho: any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore County Timonium Maryland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 21093 United States 2300 Dulaney Valley Road 12. Was Decedent Ever in U.S. Armed Forces 1 Pse 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates. Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Substitute Teacher Baltimore City Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Laura O'Donnell Louis Banknell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Royce M.Schmidt (Daughter) 17505 Bushland Road Parkton, Maryland 21120 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State (Baltimore City) Tuesday, (Baltimore City July 12,201 Baltimore, Maryland 1 Burial 2 Cremation 3 Removal from State Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. C. S. Name and direct of Facility Exercity Alternatives Funeral and Cremation Center, P.A.

Tic. #M00677 7825 Verk Read Timenium, Maryland 21093-2215 any in 23a. Pot 1. Intenthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ler disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): -transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Colon 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No has page After this certificate I 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 1 NO မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending death. Accider Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 32882 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD Robert Moss, M.D. TIMONIUM 21093 MD31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

ELLLIOTI

A.M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-- State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Day Physician/ 6:45 P M 2011 **CYPRESS** 07 NETTIE LEE EVANS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY **BETHESDA** MANOR CARE BETHESDA NURSING HOME 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 🗆 M 2 🛛 I Months 12/20/1920 Director 228-56-8764 90 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MACKLENBURG BRACEY VΑ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 23919 190 FRANK LANE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give "natural", BLACK Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 if Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) DOMESTIC HOUSEWIFE other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ MARGARET CYPRESS MATTHEW WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Q St. SE Apt 1. WASHINGTON, DC 20020 SHIRLEY EVANS PARKER/DAUGHTER Page 1 and 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of , <u>=</u> cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or ROANOKE ZION RZUA CH. 07/13/2011 BRACEY, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility
WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A.
1206 W. NORTH AVE. BALTIMORE, MD 21217 21. Sign re of Funeral Service Liv and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** POSSIBLE ASPIRATION PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FAILURE TO THRIVE Sequentially list conditions Due to for as a curisquence of n any, leading to immediate cause. Enter Underlying Exam Cause (Disease or iinjury B12 DEF ANEMIA and that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical RIGHT ABOVE KNEE AMPUTATION Box 68760 use as attending plant in the second IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Year Day Pregnant at time of death Other (specify) signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 HYPERTENSION 2X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an DIABETES MELLITUS autopsy perform certificate Yes 2 X No the Hospital or Attending Physician; 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directions. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27 Manner of Death 28d. Describe how injury occurred Certificate 1 X Natural 5 Pending Acciden
Sulcide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Registrar

(Check

29b. Signature and title of certifier

7710 BRADLEY BLVD. BETHESDA, MD 20817 KIRTI VOHRA M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D-20274

29d. Date signed (Month. Dav. Year)

7/9/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N	lental Hygie	ene	22055
			Registrar 1. Decedent's Name (First, Middle, Last)	runcate or Death	2. Date of Death	g. N6., U	C C U C C
F	Physicia		Doris Gertrude Erbe			07, 2011	3. Time of Death 06:19 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July	4c. County of Death	
			514 Kent Road	Glen Burnie			rundel Co.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		578-22-7865 1 M 242 89 Yrs. Usual Residence of Decedent	Inomine Days Frodis Hims	(Month, Day, Ye	1921 Mar	yland
pu	at	2	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
Aaryla	8a-f s tiffied	Director	MD Anne Arundel Co. Glen Bu	rnie			1 🗌 Yes 2 ื No
the N	or 2	<u> </u>	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
nd 21215-0036 filed within 72 hours after death with the Maryland	is 23a nust b	Funeral	514 Kent Road	21060		United St	ates
death	item ner n		11. Marital Status 1 Never Married 2 Married	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36 after	al", or xami	d by	1 L Never Married 2 L Married 1 L Yes 2XX No	1 ☐ Yes 2 🔀 No Specify:		Specify: Whi	
ours	atura Ical E	Completed	Total of Dates.	dent's Usual Occupation	14	6b. Kind of Business In	
215	an "n Medi	ם	(Specify only highest grade completed) (Give	kind of work done during most of worki OO NOT use retired)	ng	DD. KING OF BUSINESS IN	dustry
Nath N	grene rer th t, the			<u>lerical</u>		US Gover	nment
ind filed	d oth	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Mai	iden Surname)	
Marylan should be file	narke narke natic	-	Walter Crawford	Anna	Fischer		
Mai Ssho	n and		Maro Nomera I Combal / James Lang	ng Address (Street and Number or Rura			
and	or heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Dispo	Patuxent Road #63		n,Marylan Oc. Location - City or To	
Page 1	ort of nt: If ii y or c		1 ☐ Burial XX Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	Department of Important: If it any injury or conce.	- 4		2. Name and Address of Facility Sin		len Burnie	
m F	i i ii ii		M01121 Se	ervices PA; 1 2nd	Ave. SW;	Glen Burni	e, MD 21061
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac c	r respiratory arrest	,	Approximate Interval Between
	sician/	8 4	Immediate Cause (Final disease or condition / H 4	astatic nel	4n044		Gnset and Death
	/ledical aminer		resulting in death) a. Due to (or as a consequence of):				
		ř.	Sequentially list conditions, if any letter for as a consequence of				
, p	ısıt	Examiner	cause. Enter Underlying Cause (Disease or linjury				
D in section	n and al-tra	Exa	that initiated events c. The property of the				
certificate be executed	physician and the burial-transit	dical	d				
6876 ertificat	ng ph as th	Mec	IF FEMALE:				
S H	tendii or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deliv	,
BOX	the at hed fo	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month	Day Year
that the	been signed by the attending pl should be detached for use as th		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
	signe Id be	d by			1 ☐ Yes	2≯No 3□ Pro	bably 4 🗆 Unknown
cords,	s beer shou	olete			24a, Was an	24b. Were auto	psy findings available
Hec The lav	certificate has birector, page 2 s	Completed			autopsy performe 1 Yes 2	d? death?	mpletion of cause of
<u> </u>	rtifica ctor, p		25. Was case referred to medical examiner?	26. Place of Death (Check	-	ALINO I LES	22110
VII hysic	his ce Il direc	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me_5 KResidend	ce 6 Other (Specify	2
O C	After t	Certificate:	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe how	injury occurred	
SIO	the /	‡i	2 Accident Investigation 3 Suicide 6 Could not be 4 Despision determined 28e. Place of Injury - At home, farm, str	M 1 Yes 2 No	007		(B.) Al. (b.)
DIVISION OF VITAL RECORDS, tal or Attending Physician: The law requires after death.	Dire d in b	Se	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	cet, factory, office	City or Town, S	et and Number or Rura State)	r Houte Nurriber,
L ospita hours	To the Funeral Director. After this certific completed filled in by the funeral director.	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	d due to the cause((s) and manner as state	ed.
in 24	the Ft	Mec	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investorly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and r	place, and due to the ca	use(s) and manner stated.
To t	TO 1		29b. Signature and the of certifier	29c. License number	29d	I. Date signed (Month,	Day, Year)
	_		1 / brette	103/55	1 -	uly 1,2	011
-	り		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Hospital Di	ve PL	Burn h	17/01/
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TOSPICOS IVI	vyvrm	1~ U + 1) 17 / 1	u. 2106/
	Registra	ır	JUL 12 2017 James B. Jak				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 07 Physician/ Month Edward Ferrin W. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death pasta MOSDICE Salisburu NICOMICO 8. Date of Birth (Month, Day, Year) 08/18/1919 If Under 1 Year If Under 24* (In yrs. 91 last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 XM 2 🗆 F Months Min 217-09-0570 Country) Director Yrs MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director Berlin MD Worcester 1X Yes 2 ☐ No 10f. Zip Code 21811 10e. Street and Number 10g. Citizen of What Country? Fushermans Drive "natural", or items 23a Funeral USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No
If Yes, Give Air Co 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Nidowed 4 Divorced r Yes, Give Year or Dates Air Corp Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry C | Ward | Nard | Maryland 21215 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the Shipyard Supervisor Shipping other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Ε. Ferrin Lillian Clark Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zio Code) 103 Talbot Road, Stevensville, MD 21666 Department of Health a Important: If item 27 is any injury or other trau Charles Ferrin Sr., Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey crem. 7/11/2011 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 4113, Baltimore, MD Funeral Service Licensee Dorota Marshall llon8hom 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ DIOMYO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ner Due to (or as a consequence of): Examir The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) page 2 should be detached for in the past 12 months? Dav Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 No Yes or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2/1 No Other: မှ HOSPICA 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Other (Specify) After this 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? death. 2 No hours after death uneral Director: / Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I To the Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 37 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DO058410 0

State Registrar 130P

2/502

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAR

6Huran 31. Date filed (Month, Day, Yea

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ JULY **FOSTER** 3 5:40 A MILDRED R. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min SEPT. Day 28 1931 SOUTH CAROLINA 79 578-40-7523 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location Director 1X Yes 2 No WASHINGTON DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 3204 POPE STREET S.E. 20020 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) **2YRS** Elementary/Seconday (0-12) the PRIVATE REGISTERED NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve ည SIMPKINS MARY HOWARD ROSE of Health and Mel of Health and Mel if item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10104 WELSHIRE DRIVE UPPER MARLBORO, MARYLAND 20772 ROCHELLE FOSTER/DGT. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 1 XBurial 2 Cremation 3 Removal from State FT. LINCOLN CEMETERY 7/8/2011 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Erger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ tatal Cardi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Examir burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical certificate be P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, cancer Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Anemia 1 Yes 2 X No this certificate Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 XNo ၉ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of cert

31. Date filed (Month, Day, Year,

TENEH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 ENEBE

MIS

29d. Date signed (Month, Day, Year)

Spital Dr Cheverly mo 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedept's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jul v 20^{Yea} 1:00AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Elternhaus Assisted Living Dayton Howard if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) 8. Date of Birth . Age (In yrs. last birthday, **Funeral** 1 M 2 G Months (Month, Day, Year) In. II. 1917 550-54-9005 Director 94 Jan. Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No MD Howard Dayton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4201 Linthicum Road 21036 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. 10 þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes Give Specify: White 'natural", 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with... **al Hygiene. ``or than "pr (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other t 6 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Celian Emerald Andross Jennie Louise Dickinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald Folkenberg (Son) PO Box 380, Huddleston, VA 24104 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🕅 Cremation 3 📈 Removal from State injury or Milton-Freewater Cem. | 7/8/2011 Milton-Freewater, OR 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Haight M00764 PO Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Dav Pregnant at time of death 5 Other (specify) Yes signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy perform certificate 2 40 1 Yes or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. 1 Yes 2 No Accident
Suicide Investigation 6 Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 12:35 Avis H. French JUIV 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square 5. Social Security Number Rosedale Baltimere Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 1 □ M 2 🕇 F September 20,1936 Marviland 74 Director 212-34-4713 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 ☐ Yes 2 🛣 No Baltimore Nottingham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9023 Moon Stone Road 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🙀 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White If Yes. Give Completed 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Stock Broker Secretary permit. Page 1 and 2 should be filed will Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, till once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie Helen Roth William A. Suter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9025 Moon Stone Road Nottingham Maryland 21236 Michael Lusco/Son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 7/19/11 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner ardiomyopath Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a const quence of attending physician and for use as the burial-transii To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 9 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c, Injury at work? __1 ☐ Yes _2 ☐ No 28d. Describe how injury occurred Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Ø

29b. Signature and title of certifier

Gizaw Woldenwot

Darow H. WOODEHUNT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D

DHMH 17 Rev 7/2009

State Registrar 9000 Franklin Square Drive Bultimore

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DO063327

29d. Date signed (Month, Day, Year)

2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Catherine Anne Freiert Physician/ Day 2011 July 09, 5:10 P. M Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Towson Examiner** Baltimore County Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-82-9939 1 🗆 M 2 📑 Months Days Hours 51 27, 1959 Director Baltimore, MD. Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 ੌ No Cockeysville Maryland Baltimore County 10e. Street and Number 10f. Zip Code ò Citizen of What Country?
United States 21030 318G Limestone Valley Court 23a Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces2 Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify "natural", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (7-4 or 5+) HIGHS Assistant Manager and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Maureen McDenmott William Howard Bennett, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sparks, Maryland 21152 Mr. Timothy Shawn Bennett (Bro.) 601 Priceville Ave. Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Jown, State (Harford County) Forest Hill, Maryland Sunday Exars Fureral Capel and 4 ☐ Donation 5 ☐ Other (Specify) July 10,2011 Cremation Services, Inc. 21. Signature of Funeral Service Licensee **Jeffrey L. Gair, Sr. O.S.** Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland Raft # Enist the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician MPTASTATIC LUNG CANCER disease or condition PARS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) requires that the death certificate be executed tran that initiated events resulting in death) Last and Due to (or as a consequence of) burial physician Physician/Medical P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Po Month Dav Year Pregnant at time of death Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccoruse contribute to the cause of death? by Records, OBSTRUCTIVE PULMONAY DISPASE 1 Gres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MOLLITUS 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performed' certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 140Spice 1 Yes 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: After 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No in 24 hours after death.

In Funeral Director: Af oldered filled in by the fu Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day Year **Physician** (0:5) AM Guerdon Lowman French 10,2011 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rosedale bultimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Days Hours 1 □ M 2 □ F Min. Maryland 212-34-5169 Director July 1,1937 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ral", or Items 23a or 28a-f shov Examiner must be multifued at 1 ☐ Yes 2 ▼ No Director MD Baltimore Carney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 2815 2nd Avenue 21234 USA Funeral 1 and 2 should be filed withIn 72 hours after death. Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify.white 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) American National Tool and Die Maker 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George French Edith Freeland ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2815 2nd Avenue-Carney, Maryland 21234 Irene French-spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland -12-11 and Cremation-Belair 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services hATT marse tada 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. darnying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **X**No 2 No 1 □ Yes To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Shinners

()0053694

9000 Franklin Square Drive Baltimore, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** Erma Frieders 2011 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 919 Candle Light Court Harford Bel Air 9. Birthplace (State or Foreign Country) Munderf, PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 28, 1936 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 X F Months Days 186-28-1496 May 75 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprinct must be notified an once. Harford MD Bel Air 1 ☐ Yes 2X No Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 919 Candle Light Court United States 21015 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bay City Public College (1-4or 5+) Elementary/Secondary (0-12) Schools Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenn Mortimer Beulah Wingard ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Frieders- Husband 919 Candle Light Court, Bel Air, MD 21015 Baltimore, v 12, 20b. Place of Disposition (Name of Evanser) Funder all Chapel – Bel Air 20c. Location - City or Town, State 20a. Method of Disposition July 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 3 Newport Drive, Forest Hill, MD 21050 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ediate Cause (Final **Physician** metastatic brest cancy di ease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 ☐ Other (specify) 1∐Yes 212Mo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed' certificate 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; d in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Oh July 11, 2011 040850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21237 9103 Franklin Square Drivi VONAC Ottaviano Mo 31. Date filed (Month, Day, 32.. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent (First, Middle, Last) 2. Date of Death 3. Time of Death Month. Physician/ 6: Medical Examiner T MOR 6. Sex 8. Date of Birth
(Month, Day,
June 12 Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Days Hours 85 216-32-9294 Yrs **Director** France Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Baltimore Randallstown 1 Yes 2X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 3808 Marriottsville Road 21133 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify "natural", 3xxWidowed 4 ☐ Divorced Specify. White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12th Beautician Continental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ဂ္ Jean Hager Anne Bourg Department of Health an Important; If item 27 is r any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Louis Alex Falkenklous Son 3808 Marriottsville Road Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛭 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Alphonsus Cemetery July 16,2011 Woodstock, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Ligense 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield MD ΜŃ 1212 W. Old Liberty Road
nter the mode of dying, such as cardiac or respiratory arrest, Fart 1. Enter the disease, or complications that eause hoc, or heart failure. List only one cause one, chilip d the death. Do not enter Approximate Interval Between Onset and Death Imn edi ve Cause (Final MIA Ph_sician/ dis-a- or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 1 🗌 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) after death. Director: After this Manner of Death
Natural
Accident completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State, To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nu Practioner viedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature of certifier 29d. Date signed (Mor who completed cause of death (Item 23a) (Type, Print) nomas

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

1 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 700 PM 201 Mariscie Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner cartord Chosapecke erun T Upper If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Feb. 9 Pay, Mary land f941 Director 217-38-6386 70 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ortant, If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 1 Yes 2 X No Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21040 1215 Janet Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Oak Crest Village Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Evelyn Frebert Frank Vincent Stach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is 1 any injury or other traumonce. 8101 Linden Ave. Rosedale, MD 21237 Daughter Margie Smith altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/9/2011 Glen Burnie Atlantic Crematory 22. Name and Address of Facility Schimunek Funeral Home, 21. Signature of Funeral Service Licensee 9705 Belair Rd. Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final probable Physician) disease or condition) Medical resulting in death) Due to (as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to or as a consequence of that y leading to immedicause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? Month been signed by the atte should be detached for Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 2 No 3 Probably 4 Unknown Actory disease Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law has autopsy performed death? 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examinor? Hospital Other: 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifiong Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 20 8 2011 H Dr completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who pper Chesaponice

DHMH 17 Rev 7/2009

State Registrar 1 2 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death July 8, Physician/ 2011 William Frank Feller 5:24 A M Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springhouse at Westwood Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 2, Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 D F Days 468-44-7909 Nov. 1925 Minnésota 85 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7028 Barkwater Court 20817 United States · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces?
X Yes 2 \(\square\) No Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Surgeon Hospital traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ဂ Eva C. Nordstrom William Frank Feller, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20817 7028 Barkwater Court, Bethesda, Maryland Margareta E. Feller/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Ju1y 12 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2011 Bethesda, Maryland 21. Signature of Funeral Service License ROBERT A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. A. Maryland 20814 Hultran tin 7557 Wisconsin Avenue, Bethesda, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Bladder Cancer years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the at Id be detached fo g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, been signated should the Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has al director, page 2 performed' death? 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2 **X** No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 1 Yes 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 24 hours after death. Funeral Director: After work? 1 \(\text{Yes} \) 2 \(\text{No} \) injury 1 X Natural 5 Pending Investigation Accident completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F

State Registrar only one

29b. Signature and title of certifier

2401 Research Boulevard #330, Rockville, Maryland 20850 Anurita Mendihratta, M.D. 31. Date filed (Month, Day, Year, 32. Registrar's Signature 1 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:57 PM Angela Elizabeth Ford Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Residale Brutimore Franklin HOSPITA Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. **64 Funeral** 1 □ M 2**X**) F 214-44-2455 Months Days Hours Min. 09/01/1946 MD **Director** Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 72 hours after death with the Maryland at Director or 28a-f sh notified Baltimore Middle River 1 Yes 2 XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral 9715 Laguna Rd. 21220 USA . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married ģ 2 **X**No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Board of Elections College (1-4 or 5+) . Page 1 and 2 should be filed within iment of Health and Mental Hygiene. Elementary/Seconday (0-12) Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Woodrow Wilson Myrick, Sr. Bertha Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Ford, Sr. / Husband 9715 Laguna Rd., Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 07/15/2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fuperal Service Licensee 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA M01452 4023 Annapolis Rd., Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Onset and Death Congestive Thysician/ disease or condition resulting in death) Medical Due to (s a consequence of): . Examiner fithurosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Pregnant at time of death cate has been signed by the a page 2 should be detached by g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of Diabetes mellitus 24a. Was an autopsy performe death? yes 2 No 1 ☐ Yes 2 ☐ No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 1 XNatural work? 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and tith

\X DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State of M				t of H	lealth a		lental Hy	•		22067			
ı	Physicia		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	Day	Year	3. Time of Death			
	Medic Examin											4c. County	1				
	Funeral Director					ast birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird	h l	9. Birtl	hplace (State or Foreign intry) MD			
	laryland 3a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County CARROI	L		y, Town or Lo			· · · · · · · · · · · · · · · · · · ·					10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	with the Ns 23a or 28 ust be not	Funeral Dir	10e. Street and Number 4 EAST COLLINS	CIRCLE			10f. Zip	Code L048				10g. Citizen of V	Vhat Co	untry? USA			
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ፟፟፟ Marri 3 ☐ Widowed 4 ☐ Divorced	Ever in U.S No	1	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE						, etc.					
21215-0036	within 72 horgiene. ler than "nat ler the Medica"; the Medica	Completed	15. Deceden (Specify only highes Elementary/Seconday (0-12) 12	5+)	16a. Deced (Give i life. Di Sa	lent's Usua kind of won O NOT use ALES	k done di		of workir	ng	16b. Kind of Business Industry INSURANCE						
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	and 2 shou lealth and im 27 is m her traum				19a. Informant's Name/Relationshi CAROL FRIEDMAN/			4 EAS	T COI	LINS	nd Numbe S CIR	r or Rurai CLE ,	Route Numbe FINKSE	r, City or Town, S BURG, MD	210	48	
Baltimore,	t. Page 1 a tment of h rtant: If ite ijury or ot		20a. Method of Disposition 1 M Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sc	ecify)		lace of Dispo emetery cren B SHAL	OM ME	her place M PA		7/10		20c. Location - REISTER	STOW	N, MD			
Bal	регті Depar Impol any ir		21. Signature of Funeral Service Li	Myga		8'	Name and	Addres	s of Facility ERSTC	WN F	COAD, P	IKESVILL	Ε, Ν	INC. 4D 21208			
. C	Physician/		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition	complications that caused ly one cause on each line End	the death s. Stac	n. Do not ente	er the mode	of dying	such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death			
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09/	cate be executed physician and the burial-transit	ical	resulting in death) Last	d	a consequ	lence oi).											
P.O. Box 6876	ne death certificate be executed the attending physician and ched for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	death 3	Ectopic p Other (spe		/			23d. Da Mo		ivery Day Year			
	requires that the de been signed by the should be detached	by	236. Did topacco use continuing to death but not resulting in the didentifying cause given in Part.									_	the cause of death?				
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Divis	ital or Att irs after d ral Directo lled in by t		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin				eet, factory,	office		2	28f. Location (S City or Tow		er or Rur	al Route Number,			
	To the Hospital or a within 24 hours after To the Funeral Dire completed filled in the	Medical	(Check 2 Medical Exonly one) 3 Certifying I	Physician: To the best of aminer: On the basis of extended the Practioner: To the	xamination	and/or invest	igation, in n leath occur	ny opinion red at the	n, death oc time, date	curred at	the time, date a e, and due to th	ind place, and due e cause(s) and ma	e to the canner as	cause(s) and manner stated. stated.			
9	7 ⊗ 6 00		29b. Signature and title of certifier 11 J. Riylypiv						0571			29d. Date signed 7 / 7	/11				
			30. Name and address of person w			23a) (Type, P	Trint)	5-	703	1	Baltin	ione N1	0 3	21209			
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registra	ır's Signat	bare	1										

DHMH 17 Rev 7/2009

11-05074 Aric Greenberg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ T. Aric Greenberg Month Duly 7, 2011 **Medical Examiner** 1800 hrs Greenburg 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months | Days | Hours | Min | 1. 7. Age (In vrs. last birthday) Funeral Director Months Days Hours 218-74-6730 1 XM 2 F Country) 52 PA 1959 Yrs July 7, Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 X No 28a-f show . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene retails "natients", nr iteens 23a nr 23a-f sho retail I fleen 27s an artsed nither than "natural", nr iteens 23a nr 23a-f sho or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 825 Northwest Dr. 20901 United States Funeral 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces' White, etc. 2 X No Yes If Yes, Give Yeer 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify. White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A 0 Never Worked Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Nôrman Morman Be Greenberg Jacqueline Boodman Edith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Greenberg / Brother 708 Easley St., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 07/11/2011 Chesapeake Crematory Beltsville, MD 4 Donation 5 Other Specify. 21 Signature of Funeral Service License 22 Name and Address of Facility
Rapp Funeral and Cremation Services ittl 1MD144 933 Gist Ave., Silver Spring, MD 20910 Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Seizure Disorder complicated by positional Asphyxia Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and I be detached for use as the burial - trar Physician/Medical 1 per me g91/ /-2/-11 vt X UNPENDED AMENDED 1 per me g91/ /-2/-11 VI 23a,27,28a-f,30.per me,g923 1-20-12 sm Huspital or Attending Physician: The law requires that the death certificate be. 24 hours after death. Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 __ Inpatient 2 ✔ ER/Outpatient 3 __ DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes ဥ 2 No funeral 28b. Time of Injury After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Haspna...
within 24 hours after death.
The the Funeral Director: Af-Certification: subject found wedged between seats in vehicle after seizure 1 Natural 5 Pending 1 Yes 2 X No fd 3:00 pm fd 7-7-11 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 825 Northwest Dr. Silver Spring, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined (Specify) Group Bus/Van 4 ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, M.D. Deputy Medical Examiner Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registrar DHMH 17 Rev 1/200

OCME 2006

State

Date filed (Mont) Day Yes

32. Registra s Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Mor Medical Facility Name (if not institution, give street and number) **Examiner** Kandalstown NW Hospital Baltimor @ If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours (Month, Pay Year) Country) **Director** MD Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The short of Health and Mental Hygiene. The short of Health and Mental Hygiene anti- If ifer 27 is marked of other than "natural", or items 23a or 28a-f short ury or other traumatic event, the Medical Examiner must be notified at and Mental Hygiene.
'is marked other than "natural", or items 20a to the control of the mast be notified at the medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits Randallstown Raltimore 1 Yes 2 XNo 10e. Street and Numbe 10g. Citizen of What Country? Meadow Heunts 21133 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Langshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ James Gill, Sr. Ruby Soloman 19a. Informant's Name/Relationship (Type, Rrigt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Gill 9053 Meadon Heights Road Randallstown MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of F Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: I any injury or 16/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 21. Signature of Funeral Service Licensee Greene Purioral SVB au Road andalistanin MD 23a. Part 1. Enter th disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate shock, or heart Interval Between Onset and Death Immediate Cause (Fi disease or condition resulting in death) (Final - hysician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or impury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.
within 24 hours after death.
To the Funeral Director After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burd Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Month Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 🗆 Yes 2 🗆 No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nusse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	State of Ma State Amend Item 25 per me,	g917,07/29/	rtment of Health and I 12011dhb tificate of Death	vientai Hyg F	giene Reg. No.	22071				
Physician		1. Decedent's Name (First, Middle, Last) Joan Gui	di		2. Date of Dear	th Day Year 201	3. Time of Death				
Medica Examine	_	4a. Facility Name (if not institution, give street and number) Howard County General Hos		4b. City, Town, or Location of Death Columbia		4c. County of Dea	th				
Funeral Director		5. Social Security Number 6. Sex 1	e (In yrs. last birthday) 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth		thplace (State or Foreign ountry) ssachusetts				
and show dat	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
e Mary r 28a-f notifie	liec	MD Howard 10e. Street and Number	Columb			1 🗆 Yes 2 🛣 No					
n with the	Funeral Director	7110 Minstrel Way		10f. Zip Code 21045		10g. Citizen of What Co USA	ountry?				
·	ଜ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No II	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh					
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5 5+	(Give k	lent's Usual Occupation kind of work done during most of work O NOT use retired) Director Ction Services	of	16b. Kind of Business Healthcar					
and 2 be filed wintal Hygic ked other c event, the	ωŀ	17. Father's Name (First, Middle, Last) Harry Appleton		First, Middle, Maiden Surname) ine McDonald							
<u>ත</u> දීළ හ පු	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code										
lore, M ge 1 and 2 s t of Health If item 27 or other tr	ŀ	Richard Kates (son) 5034 Three Kings Lane Columbia, MD 21044 20a. Method of Disposition Date 20c. Location - City or Town, State									
Fage Fig.		1									
Balt permit. Departr Import any inju		21. Signature of Funeral Service Incensee		Name and Address of Facility Winds							
Physician		23a. Part T. Eyler the diseas of recomplications that caused shock, of heart failure. List only one cause on each line Immediate Cause (Final		r the mode of dying, such as cardiac ebella He			Approximate Interval Between Onset and Death				
Medical Examiner		disease or condition resulting in death) a. Due to (or as a	consequence of):	0000110 110	1119771	1496					
xecuted and al-transit		Sequentially list conditions, if any head is to find definition cause. Enter Underlying Cause (Disease or linjury	consequence off:	^	1	1 Counter					
		cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. CERTIFICATION APPROVED BY MEDICAL EXAMINER									
ficate be e g physiciar as the buria		d		CERTIFICATO							
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ISION Of VITAL Attending Physician: or death. ector: After this certific by the funeral director,		1		t 3 □ DOA		ence 6 Other (Spec ow injury occurred	cify)				
To the Hospital or Attending Physician: The lythin 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page		2 Accident Investigation	ry - At home, farm, stre .(Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (St City or Town	treet and Number or Run, State)	ıral Route Number,				
To the Hospital or within 24 hours after within 24 hours after To the Funeral Director completed filled in Madical Co.		29a. Certifier (Check 2 Medical Examiner: On the best of exonly one) 3 Certifying Nurse Practioner: To the l	amination and/or investi	igation, in my opinion, death occurred a	t the time, date an	nd place, and due to the	cause(s) and manner stated.				
To the within To the compi		29b. Signature and title of certifier	the property of the property o	29c. License number	2	29d. Date signed (Mont					
5	-	30. Name and address of person who completed cause of de	Path (Item 23a) (Type, P			-					
State Registrar		32. Registra	Signatule								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 State of Maryland / Department of Health and Mental Hygiene ar _____ Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gorhan 354 John Ann 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rd. MORAVIN Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Min. 3 Hours MARYLAND J 219-62-2 Director Yrs. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Completed by Funeral Director Md. Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Sinclare 2111 US permit. Page 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health Care Elementary/Seconday (0-12) College (1-4 or 5+) Assitance Norsina Be 18. Mother's Name (First, Middle, Maiden Şurname) 17. Father's Name (First, Middle, Last) Gorham ၉ FLENMING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town State, Zip Code)
5301 MORONIA Rd. Balto. Nd. 21206 aughter 20b. Place of Disposition (Name of cemetery, crematory or other place of the place 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 Removal from State Burial 4 Donation 5 Other (Specify) Metre politica chapel Millery 21. Signature Foneral vice L 22. rame and Address of Facility BROadwa 23a. Part 1. Enter the disea shock, or beart failure Immediate Cause (Final se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rules only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Daughter' Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5803

State Registrar 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type of Printin Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 67 Day Year 1:04 PM 2011 ecinand. Gawaniki Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death University of Noryland Medical Center. 22. South Greene St Baltimere 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours Jan. 15, 1933 Pennsylvania 78 Director 177-26-9509 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 No Edgewater 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 517 Overhill Road 21037 U.S.A. items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Engineer other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Svlvester Gaworski Catherine Rubinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Wishart 1 Falcon Drive, Southampton, New Jersey 08088 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/11/2011 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 1-11-11 Bensalem, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Luneral Chapel, F.A. michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Non- ST elevation my ocerdial inferction Medical Due to (or as a consequence of): Examiner Mesenteric Ischemia 30 days Sequentially list conditions, if any county to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Respiratory Foilur that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Backerenia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 1 Yes 2 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has r page 2 autopsy performed? death? this certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔁 No 1 Tes ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 A Natural 5 Pending ☐ Accident Investigation 1 Yes 2 No the within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge of eith occurred at the time, date and place, and due to the 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) al MID 24526 07,07,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDV Walker M.D 22 South greene Street, Baltimere 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racker Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 John Goetz 5:53 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 603 Delaware Avenue Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 | F Days Hours (Month Day, Year) 10/05/1938 219 26 6992 Director 72 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 Delaware Avenue 21060 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9th Longshoreman Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) :. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot jury or other traumatic ever ပ John Henry Goetz Sr. Margaret Acton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Goetz / Wife Glen Burnie, Maryland 21060 603 Delaware Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/09/2011 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur F F reral Service Livers e 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final D125813 Onset and Death Ph. sician/ arkinson's disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a d be detached f 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been significant page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number ☐ Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year, B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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11-04952 Daniel Gobel

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State of Maryland / Department of Health and Mental Hygiene

	F	1- For State Certificate of Death	F	leg. No.						
Physiciar dedical Examin	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year								
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 820 W. Bel Air Avenue, Room 104 Aberdeen	4c. County of Death Harford	h						
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	rth (MM/DD/YYYY) 9. Bir Foreig	rthplace (State or						
Director		217-80-3886 1 Months Days Hours		puntry) Maryland						
any		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits					
	اڃ	Maryland Harford Churchville			1 Yes 2 X No					
Maryland 28a-f show	Director	10e. Street and Number 10f. Zip Code 21028	10g. Citizen of What Cou	intry?						
- 2 -		3170 Aldino Road 21028 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin		rican Indian, Black,						
leath w	=	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		White, etc.	tc.					
raffer c	D F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: Whi						
5-0036 led within 72 hours at Hygiene. other than "antural the Medical Examin		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kir during most of working life. DO NOT us		16b. Kind of Business/	industry					
036 rithin 7 ene.	Completed	12 Manager		Big Lots	Store					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical control of the control of the medical control of the medical control of the control of the medical control of the control of the medical control of the control of t	ge င	The same transfer and	Name (First, Middle, Ceclia Si	•						
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MD ad 2 sho alth and 27 in aumat		Jeremy D. Goble 3170 Aldino Road, Cl 20a. Method of Disposition (Name of cemetery,	nurchville Date	Maryland 2						
Baltimore, permit. Pages 1 ar Department of Hee Important: If the Injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or other place)								
it. Pagartment		4 Donation 5 Other Specify: Ardent Cremation, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	/-/-11 Marzullo	Hanover,Ma unera	aryLand ape ,					
Perm Depu	1	michael Promule 6009 Harford Ros	ad, Baltir	nore,Marylan						
Physician //Medical		23a. Part I. Enter the disease, or copy lications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line.	diac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death					
Examiner	-	Immediate Cause (Final disease or condition resulting in death) a. Oxycodone Intoxication Due to (or as a consequence of):			Dealii					
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	ا≩	cause. Enter Underlying Cause (Disease or injury that initiated								
d d ansit		events resulting in death) Last Due to (or as a consequence of): d.								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	n/Medical	x unpended x AMENDEDItem# 1 as noted,23a,27,28a-f	,per me,g	17 7-18-11 sm						
8760, ificate bong physic is the bunger	We 2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic past 12 months?	pregnancy	23d. Date of deliver Month	y Day Year					
Box 68 e death certi the attendin	Physicia	4 Pregnant at time of death 5 Other (Specify)								
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should tall in the funeral director, page 2 should tall in the funeral director.	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No No No No No No No No		Residence 6 🗸 Othe	er: Scene					
of \	⊢լ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		how injury occurred	_					
Sion Attendi death. ector:	턣	Natural 2 Accident 5 Pending Investigation 1 State Accident Accident Pending Investigation Fd 7-2-11 Fd 5:20 pm 1 Yes 2 x N 28e. Place of Injury - At home, farm, street, factory, office building, etc.	3	t ingested of Street and Number of R						
Divi	Certification:	3 X Suicide 4 Homicide 6 Could not be determined (Specify) found in hotel room	or Town,	State) 820 W. Be 4 Aberdeen,	l Air Ave.					
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only)	e, and due to the cau	ise(s) and manner as sta	ted.					
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated. 29b. Signature and title of certifier 29c. License number	arred at the time, date	29d. Date signed (Mo						
	_	O.C.M.E.		July 3, 2011						
	+	30. Name and address of person who completed cause of death (Item 23a)	145 04555							
	N/a	Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltin 31. Date filed (Month, Day, Year) 32. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltin	nore, MD 21223	5						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20°11 8:53 P M Eugene Richard Haasis, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard Ellicott City Lighthouse Senior Living Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day, 1926 Jan 6, 1 **X** M 2 □ F Months Hours Min Maryland 85 Director 219-10-8166 Usual Residence of Decedent r 28a-f show notified at 10b. County 10a State 10d. Inside City Limits within 72 hours after death with the Maryland 10c, City, Town or Location Director 1 ☐ Yes 2X No Ellicott City Maryland Howard 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral United States 21043 5102 Avoca Avenue 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or iter idical Examiner Black, White, etc. 9 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1944-1948 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced Completed White er than "natura , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mealone. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Insurance Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Emma Binder Eugene Richard Haasis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8614 S. Bali Ct. Ellicott City, MD 21043 Thomas Dickson /Brother in Law 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 7/14/2011 Woodbine, Maryland 4 ☐ Dogation 5 ☐ Other (Specify) Final 21. Sign up of Funeral Service Wense Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 0 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) -transit Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialphysician Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 I Inknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 U Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completed filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HYSICIAN 0062704 JULY s of person who completed cause of death (Item 23a) (Type, Print) Swire N. Ridge Road

State Registrar 3290

DOJA!

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Helen M. Headle 10:30 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Belair Senator Bob Hooper Hospice Care 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 7 F Months Hours 79 MD Director 214-28-3311 May Ĩ932 Usual Residence of Decedent or 28a-f shov 10a. State 10h. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Belair MD 1 Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 300 Sunflower Dr. #154 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. ş 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 XNo Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 🙀 Widowed 4 □ Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker n/a 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert William Cannon Nola Warfield Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Jackson Blvd., Belair, MD 21014 Brenda Lee Ford/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Garrison Forest Vet. Cem. 7/6/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Se Vice Michael 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final STAGE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year 5 Other (specify) Month Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 BUCTIVE PULMONARY 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 24 hours after death.

Funeral Director: After this certificate has the Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence ည 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature ar 29d. Date signed (Month, Day, Year) npleted cause of death_(Item 23a) (Type, Print) Date filed (Month, Day, Registrar

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James L. Headle		1- For State	tate of Maryla	•		ent of ate of		and	Menta	al Hy	_	Dag No	20	B	22078
Physician	Registrar								2	2. Date of De			3,	Time of Death	
Medical Examine										Month July 4, 2		Year		2051 hrs	
•		4a. Facility Name (if not institution Johns Hopkins Bayvio				41	. City, Town, Baltimore		cation of I	Death		4	c. County of I	Death	
Funeral	T	5. Social Security Number	6. Sex	7. Age (In yrs.	last birt	hday)	If Under 1 Y	\rightarrow	if Under		1		/DD/YYYY)	oreign	
Director	L	218-70-6229	1XM 2F		52	Yrs.	Months D	ays	Hours	Min.	July	12,	1958	Country	Maryland
au À	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c Cit	v Town	or Location	1							100	d. Inside City Limits
		MD N/A Baltimore								1 Yes 2 X					
or 28a-f show	DIFECTOR	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?					
the M		1108 Bunbury Way 21205										USA	A		
h with	nuera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe							Indian, Black,						
er deat	5	1 X Never Married 2 N 3 Widowed 4 Div	1 Yes	2 X No			′es 2 💢					nite			
urs aft.	<u></u>	15. Decedent's Education (Spe	or Dates:		16a.		Usual Occu			d of wo	rk done	16b.	Specify: Kind of Busin		
72 hor	ere ere	Elementary/Secondary (0-12)	College (1	-4 or 5+)	۱ ۱	during mos	t of working I	life. D0	O NOT us	e retire	d)				
5-0036 ed within 72 hour lygiene. other than "natu		8	N/	A	<u></u>	Contr	uction						mmerc	ta1	
filed of the color		17. Father's Name (First, Middle	•					18.1	Mother's I		First, Middle Len M.				
2121 uld be fil marked r event,		James J. Head 19a. Informant's Name/Relations			198	. Mailing A	Address (St	reet ar	nd Numbe				ity or Town,	State, Zip	Code)
MD 12 sho th and 27 is	7	Brenda L. For	rd/ Sister			223 J	ackson	n B	lvd.	Вє	el Air	, MI	21014	4	
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Itien 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition 1 Burial 2 Cremation	3 Removal fro			of Disposition	on (Name of place)	cemete	ery, J	uly	Date 9.	20c.	Location - Ci	ty or Tow	n, State
Page Page ment of tant:	ų.	4 Donation 5 Other S	pecify:	A	tlar		Cremat	_		20	11				ie, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. TO BE Completed by Ericascal Dispose.	м.	21. Signature of Euneral Sprvice		TT 1		22. Nar L e	me and Addre	ess of Fun	Facility era1	Hon	ne of	Dula	ney Va	alley	, Inc.
Physician	+	23 Part I Enter the disease, or	diehael J. complications that ca	FLag1	e h. Do no	t enter the	M. Pa	ado ng, suc	nia th as card	Roac liac or r	espiratory a	rrest, sh	ock, or heart	2109 A	pproximate Interval
/Medical	1	failure. List only one cause Immediate Cause (Final disease	01:	d drug(Metl	nadon	e Oxyc	ođo	ne.F	ree	Mornh	ine	intoxica		etween Onset and Death
_xammer	1	or condition resulting in death)	Due to (or as a												
1		Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):									-	
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30x 68760, leath certificate be attending physical for use as the but	D 🛏	F FEMALE: 3b. Was decedent pregnant in th	23c. If yes, c	outcome of pre	gnancy				Ectopic pr			23	d. Date of de		Year
x 66 h certi tendin r use as	2	past 12 months?	4 Pregna	ant at time of d	eath 5	=	death (Specify)	,	_ctopic pi	egnanc	·y		WORL	Day	real
Bo ne deat the at the at for hed for	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1									(1.10					
P.O. E s that the d	5	Part II. Other significant condit	ions contributing to	death but not	resumng	in the und	eriying caus	e giver	nın Partı	v	_				ause of death?
cords, P law requires that has been signed to a should be defined to the property of the state o		_								_	24a. Was				y findings available
COI te law ie has te has te has te man	24a. Was an autopsy prior to comple death? 1 Ves 2 No 1 Ves														
25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No 1 No Yes 2 No 1 No 1 Yes 2 No 1 No 1 Yes 2 No 1 No 1 No Yes 2 No 2 No 2 No Yes 2 No 2 N								res	2 No						
f Vital Physician or this certi ral director		examiner? 1 ✓ Yes 2 No	Hospital: 1 lr	npatient 2	ER/Ou	tpatient 3	B DOA	Oth	er ₄ N	ursing l	Home 5	Reside	nce 6 C)ther:	
ding Ph. After ti	<u> </u>	27. Manner of Death 1 Natural 5 Pend		of Injury Day,Year)	28b. T	ime of Inju	· I _		Work?		28d. Describe how injury occurred				
ivision or Atten after deatt Director: I in by the	3	2 Accident Inves	stigation 10 /-	4-11 of Injury - At h		8:15	pm		2 X No		nknow		nd Number o	r Bural B	oute Number, City
Division o spital or Attending hours after death. neral Director: After filled in by the fune. Certification:		3 Suicide 6 K Coul 4 Homicide deter	d not be (Specify)		iden		dotory, omoc	Dalla	ing, etc.	- _	or Town, altimo	State) 💄	.106 Bi	ınbur	y Way
Hospi 24 hou Funer stely fil		29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowled	dge, dea	th occurred	d at the time,	date a	nd place,	and du	ie to the cau	se(s) an	d manner as	stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burifical Certification: To Re Completed by Physician/Medical Certification:		one) 2 Medical Exa	miner:On the basis o and manner st	f examination a ated.	and/or in	vestigation				red at th	ne time, date				
2	2	29b. Signature and title of certifie	r . 1. —11 ~				29c. Lice	nse nu C.M.E		00	ME	1	Date signed	(Month, E	Day, Year)
X		7 headon	Mr. Kin	y In.	1220	.),		IVI.E		00	4 V F T	July	5, 2011		
3) (2)	13	80. No me and address of person Theodore M. King, Jr.,	1.6	nt Medical I		ner 90	0 W. Balt	imore	e Stree	t, Balt	timore, M	D 212	23		
State Registra	~	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signat	ure										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For	State of Mar	yland /				Mental Hy	giene		22079		
		1	State Registrar	l not)		Cen	ificate of D	reatri	2. Date of Dea	Reg. No.		3. Time of Death		
Physi		1	Decedent's Name (First, Middle,	Hard	V S	r			Month	08	2011	85:59 Am		
/Med Exam			a. Facility Name (If not institution,	77.7	1		4b. City, Town, or	Location of Death		4c. Cou	unty of Death			
,e9#			Johns Hopkins Bay			. (1 (5)	Baltimore If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	N/A	iplace (State or Foreign		
Funera		5	Social Security Number 217 56 3457	5. Sex 1 🕱 M 2 🗆 F 7. Age ((In yrs. last b 59	Yrs.	Months Days	Hours Min.	04/10	y, Year)	Coul	Florida		
Directo	1	ι	Jsual Residence of Decedent						1 04/10	11552				
ırylanı show	_		0a, State 10b. County		10c. City, Tov							10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
he Ma 28a-f ptifiec	Director		Maryland Anne Oe. Street and Number	e Arundel	Ва	1tim	ore 10f. Zip-Code	· · · · · · · · · · · · · · · · · · ·		10a Citizen	of What Cou	intry?		
with t			5710 Moore Str	eet				1225		U.		····· ,		
death with the Maryland tms 23a or 28a-f show must be notified at	Funeral	1	1. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		pecify Yes or No Rican, etc.)		Race - Ameri Black, White			
ING 21215-UU36 be filed within 72 hours after death with the Marylan tital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۾ ا	5	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced)		Yes 2 TNo	Specify:	, , , , , , , , , , , , , , , , , , , ,			hite		
5-0036 72 hours aft natural", or	Completed		15. Decedent's (Specify only highest	s Education grade completed)	16	(Give	ent's Usual Occupa	luring most of wor	king	16b. Kind	of Business/I	ndustry		
e filed within 7 e filed within 7 all Hygiene. other than "r	a	-	Elementary/Secondary (0-12)	College (1-4 or 5+))		OO NOT use retired;				Bank			
filed v Hygie other i	ပိ	3 -	7. Father's Name (First, Middle, La					18. Mother's Nar	ne (First, Middle, Maiden Surname)					
	To Be	1	Ca	rl Hardy				E1ea:	nor Shij	pley	1ey			
Maryland d 2 should be file th and Mental Hy 7 is marked oth	4		9a. Informant's Name/Relationshi Michael C. Har				g Address (Street							
C = 64 F					1				Jnit /0/		ion - City or	MD. 21230		
0 0 0 = 5		-	20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Holy	tery, cren	sition (Name of natory or other places Cemete	ery 07/1			,	Maryland		
Baltim permit. Pag Department Important: any injury of	9	2	21. Signature of Funeral Service Lie	censee	1	22	. Name and Addres	ss of Facility Go	nce Fun	eral S	Service	P.A.		
n 885 %	티	I	23. Part I. Enter the dis-se,	romerous	M	!	001 Ritch		_		e, Mai	rýland 21225 Approximate		
			shock, or heart failure.	ly one cause on each line.	ne death. D	مل م	er the mode of dyin	, such as cardia	Orrespiratory	11651,	1 40	Interval Between Onset and Death		
Physiciar /Medica			disease or condition resulting in death)	a. Due to (or as a	consequence	ce of):	XIC YU	knu -	10m 1	14 Pog	ly ceny	a		
Examine			Commission that according on	,	12	ĺ								
Λ/D ≒	i d		Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e of):								
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687 tificate tig phys	Med	3	IF FEMALE:											
Box 6 Jeath certific attending p	in	a	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal dea	ath 3	Ectopic pregnanc	y		230	d. Date of del Month	livery Day Year		
P.O. El lat the des to by the at the detached f	Physician/Me	200	1 Yes 2 No	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of death	5 [Other (specify)							
	2		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								acco use contribute to the cause of death?			
rds quires n sign			_ Stroke	>					1 🗆	Yes 2	s 2 No 3 Probably 4 Unknown			
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f Vital Re ysician: The la s certificate ha director, page	5	5							1 Tes	ormed? 2 No		2 □ No		
Vital sician: Th certificate lirector, pa	å	0	25. Was case referred to medical examiner?	Hospital: 1XInpatien		Outpotion	t 3 DOA Oth	er:	ith <i>(Check only c</i> Iome 5 ☐ Res		Other (Sne	cih/)		
Of Phys rthis c	12		27. Manner of Death	28a. Date of Injury	/ 28	b. Time c	f 28c. Injur	y at	28d. Describe					
ion nding ath. ': After	1		1 Natural 5 Pending investig	ation	rear)	Injury	M 1	Yes 2 ☐ No						
Division of Vital to Attending Physician: Tafer death. Director: After this certificate d in by the funeral director, p	Cortification	erance	3 Suicide 6 Could n 4 Homicide determine			, farm, str	eet, factory, office		28f. Location City or To	(Street and a wn, State)	Number or R	ural Route Number,		
Division o To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral	Modical		29a. Certifier (check only one)	g Physician: To the best of Examiner: On the basis of e and manner stat	examination	dge, deat and/or in	n occurred at the tirvestigation, in my o	me, date and plac opinion, death occ	e, and due to the	e cause(s) a e, date and p	nd manner a place, and du	s stated. ue to the cause(s)		
To the within to the complex	M	Š Z	29b. Signature and title of certifier				29c. Licens	e number		29d. Date s	signed (Mont	th, Day, Year)		
2			Mus &	A M	D		ITT	325		Ju	Jy 0	8 2011		
10			30. Name and address of person	14	eath (Item 23	Ba) (Type	Print)	4040	Footors A		Politim-	oro MD 01004		
\	State		31. Date filed (Month, Day Year)	- 32. Registrar	's Signature			4940	Lastern A	venue,	Daitilli	ore, MD, 21224		
	State istrai			2 2011 Jane	-		here!							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JULY 2011 **BETTYE** 06, 10:38 AM HURWITZ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ATRIUM VILLAGE BALTIMORE OWINGS MILLS Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🗓 F Months Days Hours Month Day Year) 16 95 215-03-2519 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify Specify: 3 Widowed 4 X Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY MIZANSKY MARY FRANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHONA FARRELL/DAUGHTER 12046 LONG LAKE DRIVE, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
PROGRESSIVE RUDOMER
VEREIN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 07/10/2011 BALTIMORE, MD 21. Signature of Funeral Serv 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying as a consequence of): Cause (Disease or linjury that initiated events Dert Due to (or as a consequence of) resulting in death) Last

Physician Medical **Examiner**

Physician/

Examiner

Funeral

Director

or 28a-f show notified at

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er than "natural", or items 23a or the Medical Examiner must be

n and Mental Hygien

traumatic

permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

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Medical

and trar burialphysician s the burial attending for use as nse

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I hours after death uneral Director: A ed filled in by the fu

within 24 hours a

To the Funeral C

completed filled

that the death certificate be Box 68760

Hospital or Attending Physician: The law requires Division of Vital Records,

P.O.

Examin Physician/Medical by Completed page 2 Be

၉

Certificate:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

2 X No

5 Pending

Investigation 6 Could not be

determined

examiner?

1 Yes

27. Manner of Death

1 Natural

Accident

Suicide

4 Homicide

only one 29b. Signature

29a. Certifier (Check

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death

demention

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy perforn ASST LIVING

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🗌 Yes 2 🗌 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0068252 Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Greens nas

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 2208! Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2}\underline{011}$ Physician/ 7 Fiona Hancox July 1:00 A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min. 578-70-8646 Yrs Director 67 February 10, Scotland Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No Maryland Montgomery Rockville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 10401 Grosvenor Place # 815 20852 United States 1 and 2 should be filed within 72 hours after death in fleath and Mental Hygiene. item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian event, the Medical Examiner Armed Forces?
1 Yes 2 No Black. White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paralega1 Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leonard Thomas Hancox traumatic Martha Hepburn Thomson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violet Smith / Friend 5812 Ipswich Road, Bethesda, Maryland 20814 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. July 9, 2011 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 100 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cardiopulmonan arrest Medical resulting in death) Due to (or as a consequence of) Examiner malignanu Sequentially list conditions, cause. Enter Underlying Exami signed by the attending physician and defeached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown within 24 hours after death.

To the Funeral Director. After this certificate has been signompleted filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes al or Attending Physician: T s after death. Il Director, After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

belle

1 2 2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

0/00

3.110f-F.

HANCOX

Christine Castro, D.O. 8600 Old Georgetown Road, Bethesda, Maryland 20814

H67490

July 7, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 JUNE ESTELLE Ρ. ISABELL 6:43 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Woodside Center 9. Birthplace (State or Foreign Country) VA Social Security Number If Under 1 Year 6. Sex If Under 24 Hrs. Funeral 7, Age (In vrs. last birthday) 8. Date of Birth Oct 16, 1928 1 🗆 M 2 🔀 F Min Months Days Hours Yrs Director 227-50-2851 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Tes 2 X No DC Washington 10e. Street and Number ō 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 20002 606 13th St. NE USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. 1 Never Married 2 Married δ 2 XNo Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the N 12th Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic eve once. 2 John W. Thomas Georgianna Bagley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine MCCottry-Daughter 1314 Hemlock St.NW Washington, DC 20012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Matthews Cemetery 17-3-2011 Kenbridge, VA 21. Signature of Funeral Service Licenses Marshari1dd Marchill Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No for 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown hed 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an · has page 2 performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 1 X Natural injury 5 Pending Accident Investigation 24 hours after dear Funeral Director: completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 068583

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State Registrar

Registrar JUL 1 2 201

31. Date filed (Month, Day, Year)

+ WAISONA, MO 9101 And Ave Silver Spring; MO
32. projectrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Sandra Lee Jones - Flynt A M July 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 88 German Chapel Road Calvert Prince Frederick Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Months Hours Min. 12/25/1957 Country) 578-88-4533 Director D.C. Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland at Director or 28a-f sh notified a Prince Frederick Calvert MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 23a USA 88 German Chapel Road 20678 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iten edical Examiner Armed Forces?
1 ☐ Yes 2X No Black White etc ģ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 is marked of traumatic even မ Merle Blair Martha Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Merle Blair/ Father 960 Pat Lane, Huntingtown, MD 20639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗀 Removal from State Final Journey Crem. 7/12/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD Moustrall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pulmonary Embolism Sequentially list conditions, if any leading to immediate Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and burial-tran Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperstension, Chronic Obstructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available Pulmonary Disease 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ျ 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifig Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practice: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 0037588 July 8, 2011 381 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rafik Aboul-Nasr, M.D. PO Box 269, Lusby, MD 20657 31. Date filed (Month, Day, Year JUL 1 2 2011 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rosie Eva Jones :55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A -TIMORE 5. Social Security Number 227 – 46 – 0087 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde Birtripi VA **Funeral** Days 1 🗆 M 2 🔀 F Months Min. 1 1777 7 38 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State ^{0c. City, Town or Location} Baltimore Director N/A MD Yes 2 No 10f. Zip Code 21215 10g. Citizen of What Country? 10e. Street and Number Funeral 4318 Resiterstown Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No
If Yes, Give African þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: SpecifyAmer, Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Self College (1-4 or 5+) Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Bulter Roger Bulter 19a. Informant's Name/Relationship (Type, Print)
Jerome Jones, Sr./Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 4318 Resiterstown Rd, Balt., MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balt., MD 7/16/11 cemetery, crematory or other place)

. Zion Cem 1 Nurial 2 Cremation 3 Removal from State Mt. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fun Jal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed^a 1 Yes 2 No 2. No certificate 25. Was case referred to medical examiper?

1 Yes 2 No I director, 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifier MD que la 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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JONATHAN 31. Date filed (Month, Day, Year, JUL 1 2 2011

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:35 PM Μ. JONES DORIS Jul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Hospital Prince George's Laurel aure 6. Sex Age (In yrs. last birthday) If Under Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 X F Months Days Hours Min Director 578-52-4080 73 1938 WASHINGTON, DC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at yerinit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature". 10a. State 10d. Inside City Limits 10c City Town or Location Director PRINCE GEORGE'S CAPITOL HEIGHTS 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7005 HASTINGS DRIVE 20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married BLACK If Yes, Give Year or Dates 1 Yes 2X No Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PATHOLOGY SPECIALIST GOVERNMENT 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHARLES E. WASHINGTON, SR. SELINA PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 500 WILLOW HILL COURT LANDOVER, MARYLAND LEO WASHINGTON/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEME. 7/11/2011 BRENTWOOD, MARYLAND 21. Sign ture of Funeral 9 J. B. JENKINS FUNERAL HOME, INC. 22, Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or hear failure. List only one cause on each line. nterval Between On t an Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Renal Sequentially list conditions, Examiner Due to jor as a consequence of if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 년. 일 Other: 1 🗌 Yes 2 XNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 3 ☐ Suloido 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 certifying Nurse Practioner: To the begind fmy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl of certifie 081 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Landover Road Murth 6130

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year DONALD ANTHONY JONES SR. JULY 2011 8:02 Δ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2102 LAKEWOOD STREET SUITLAND PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Day, (Month, Day, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Min **Director** WASHINGTON . DC 577-50-0509 SEPT 1937 Usual Residence of Decedent 28a-f shov ms 23a or 28a-f shor must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2102 LAKEWOOD STREET 20746 USA 12. Was Decedent Ever in U.S.
Armed Forces? AIRFORCE
1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BUS DRIVER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ pe **NELSON JONES** LOUISE ANTHONY and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s t of Health a If item 27 i AUDREY JONES/WIFE 2102 LAKEWOOD STREET SUITLAND, MARYLAND 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 Department of Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State MD VETERANS CEMETERY 7/12/2011 4 Donation 5 Other (Specify) CHELTENHAM, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ DIABETES MELLITUS Medical Due to (or as a consequence of Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last -tran Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Pregnant at time of death Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2x No Yes 2 X No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After work? 1 Yes 2 No iniury 1 XNatural 5 Pending Division n 24 hours after death.

le Funeral Director: A
bleted filled in by the ft Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 6 pm D40635 July 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 MERCANTILE LANE, LARGO, MARYLAND 20774 Ethiopia Abebe, M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 23a, pt I per PHYS, G931, 9725/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July ^{Day} 2011 James 7 10:00 a M Jones Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12800 Peachleaf Court Prince Georges Upper Marlboro 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Days Hours Min (Month, Day, Year) 11-15-1943 **Director** 579-56-7387 67 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Md P.G Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? Funeral 12800 Peachleaf Court 20774 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S.

Armed Forces?

1 X Yes 2 □ No

If Yes, Give 1965–1967

Year or Dates. Black, White, etc. o, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 treet of Health and Mental Hygiene. tant: If item 27 is marked other than 'jury or other traumatic event, the Me Office of Personnel Elementary/Seconday (0-12) College (1-4 or 5+) Management Personnel Staffing Specialists Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Jones Estelle Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Delores Reynolds Jones - Wife</u> 12800 Peachleaf Court, Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once, 4 Donation 5 Other (Specify) Cheltenham Veterans dem. 7/14/11 Cheltenham, Maryland Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Maryland 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Colorectal Cancer Medical Due to (or as a consequence of) Examiner Obstructive Uropathy Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). -transi executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day the detached 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Atrial fibrilation, Coronary artery disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No Hypertension 24a. Was an page 2 s autopsy performed? Yes 2 X No this certificate Diabetes Mellitus type II To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: မ 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined after City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Fractioner: It the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Louerchou Jocelyne D 63748 July 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, MD - 4041 Powder Mill Road, #600 Beltsville, Maryland 20705 JUL 1 2 2011 31. Date filed (Month) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician** 2011 3:00 A^{M} MARIAN JURKIEWICZ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2804 ROSALIE AVE BALTIMORE N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 15,1916 Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Min. 1 ☐ M 2 ☐ F Months Days Hours POLAND **Director** 215-42-0707 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show :7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tra Medical Examiner must be notified at Director 1 □ Yes 2 □ No N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 POLAND 2804 ROSALIE AVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X** No altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🗓 No Specify: Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) APARTMENT 12 CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANELA STASZKIEWICZ STANISLAW JURKIEWICZ ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau 4816 BUCK SCHOOL HOUSE RD BALTIMORE, MD 21237 MICHAEL JURKIEWICZ-SON 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY CROSS CEMETERY 7/13/11 BROOKLYN, MD 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licensee BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure of only one cause on each line. Immediate Cause (Fixe) Physician disease or condition resulting in death) asonard /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 🖵 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica itely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d., Date signed (Month, Day, Year) > SM of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Jeral d WP

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 0 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Alice Manor Nursing Home Baltimore Social Security Number 8. Date of Birth Oct 27, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Min. Days West Virginia Yrs Director 221-20-0992 76 Usual Residence of Decedent show 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 2095 Rockrose Ave. 21211 USA items Page 1 and 2 should be filed within 72 hours after death 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces?unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) machine operator Department of Health and Mental Hygin Important: If item 27 is marked othe any injury or other traumatic event, once. Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardie Shaw - legal guardian 201 E. Baltimore St - 15th f1r; Balto, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 □ Donation 5 N Other (Specify) in state Signature Lice Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of Exami burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death detached Unknown g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has performed autops death? Director: After this certificate 2 NO 1 Yes 25. Was case referred to medica Be 26. Place of Death (_heck only one) 1 Tyes 2 100 Other: မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) funeral Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending injury work? 1 Yes Division hours after death 2 No filled in by the 1 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier peted (Check Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifie 30. Name and address of person who completed cause of death (Item 23a) 0

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JURAS Medical a. Facility Name (if not institution, give street and number **Examiner** ouny CO14 mbia If Under 1 Year If Under 24 Hrs. Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Min. 218-03-1931 1**X** M 2 □ F Hours MARYLAND Director 88 /2/1923 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE TOWSON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 8316 WYTON ROAD 21286 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 Yes 2x No Specify WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Manany injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) CONTINENTAL CAN CO. PRODUCTION MANAGER 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH M. JURAS, SR. MARGARET B. WEBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH M. JURAS/SON 9576 JOEY DRIVE ELLICOTT CITY, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State MORELAND MEM. PARK 7/11/2011 4 Dongtion 5 Other (Specify) HILLENDALE, MD 21. Sign sture of Juneral Sex Ice Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ureo disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi) and I-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Box 68760 attending p for use as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed the Hospital or Attending Physician: The 1 Ves 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 / No Other: 1 Tyes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury after death. 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) rpleted filled in by 4 \square Homicide determined 24 hours Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie D 30641 2011 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 201-109 Back Rud Neck Road Sabapalmi 31. Date filed (Month, Day, Year) . Registrar's Signature State 1 2 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #160 Per FH G91/20/2011 JH. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** $\underline{p}^{\mathsf{M}}$ 9, July 2011 2:35 For Hai Kam /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 408 Doe Meadow Drive Owings Mills If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₹M 2 □ F July 18,1954 213-02-7658 56 China Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It will be also miner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 408 Doe Meadow Drive 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Asian 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2121 and Mental Hygiene. Elementary/Secondary (0-12) Nordstroms College (1-4or 5+) 12 Chef Nordstram Cafe 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ၉ Wood Man Kam <u>Tai Yau Kam</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other tratonce. Kwai Ying Kam Wife 408 Doe Meadow Drive, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saints' Cemetery 7/18/2011 Reisterstown, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee ELINE FUNERAL HOME Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** andio vaseu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence or) Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) ned by the a detached fo Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, been signe should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Shknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed certificate 1 ☐Yes 2 ☑No 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death. e Funeral Director: Affer t letely filled in by the funera After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

DHMH 17 Rev 1/2001

State Registrar md title of certifie

Year)

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30. Name and address of person who comple

29b. Signature

31. Date filed (Month, Day,

M

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mble

ed cause of death Item 23a) (Type, Print)

32. Registrar's Signati

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aquan Kenned	у	State of Maryland / Department of H 1- For State Registrar Certificate of Department of H			2011 g. No.	22092				
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Saquan L. Kennedy		2. Date of Death Month	Day Year	3. Time of Death 0849 hrs				
)			City, Town, or Location of Dea	July 4, 201	4c. County of Death					
		Anne Arundel Medical Center A	nnapolis		Anne Arundel					
Funeral Director		213-73-3556 _{1XM 2 F} 6 Yrs.	Under 1 Year If Under 24H Ionths Days Hours M	8. Date of Birth	(MM/DD/YYYY) 9. 8 irtl Foreign Cou					
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1								
	'n	MD Anne Arundel Annapolis		1 Yes 2 No						
th the Maryland 23a ur 28a-f sho notified at once.	Director		f. Zip Code	109	g. Citizen of What Coun	ry?				
th the 23a nr		1127 W. Lombard St.	21223	USA						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", nr items 23a nr 28a-f she injury nr other traumatic event, the Medical Examiner, must be notified at once	r Funeral	1 Never Married 2 Married Armed Forces? If Yes, s 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Giva Year	cedent of Hispanic Origin? (specify Cuban, Mexican, Puer 2 X No specify:		14. Race - Americ White, etc.	an Indian, 8lack,				
ours af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U	sual Occupation (Give kind o		16b. Kind of Business/Ir					
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use re	etired)	27 / 2					
5-003 led within Hygiene. other th	Comple	Kindergarten N/A N/		me (First, Middle, Ma	N/A					
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	BeC	Anthony Kennedy Sr.		chele Ba	· ·					
21; hould then ond Mer is mar	2	19a. Informant's Name/Relationship (Type, Print)	dress (Street and Number o	r Rural Route Numb	per, City or Town, State,					
MD and 2 sho salth and em 27 is raumati		Telethia Hood- Sister 1927 N	. Collingto		Balto., M					
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is m injury or other traumatic.		1 \(\overline{\text{N}}\) Burial 2 \(\overline{\text{Cremation}}\) Cremation 3 \(\overline{\text{Removal from State}}\) Removal from State \(\overline{\text{Mt. } Zion}\)	Cemetery 7/		•					
Balt permit. Depart Import injury		1 // 1/ 1/1 1/	end Address of Facility M Baltimore	larch F/	H 1101 E.	North				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.				Approximate Interval Between Onset and				
/Medical Examiner	ì	Immediate Cause (Final disease a. Drowning				Death				
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):								
	Jer									
	Examiner	cause. Enter Underlying Cause (C								
cuted ind transit	Ā	dd.								
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Medical	UNPENDED								
3760, ificate be g physici s the buri	Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal december 1	eath 3 Ectopic pregi	nanov	23d. Date of delivery	Voor				
ox 6876 eath certificat attending ph	icia	past 12 months? 4 Pregnant at time of death 5 Other	eath 3Ectopic pregi (Specify)	nancy	Month Da	ay Year				
BOX he death c y the atten by the der us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		Loo. B: 11.1						
P.O. es that the igned by oe detac	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		acco use contribute to the 2 No 3 Proba					
ds, require	Completed			24a. Was ar		ppsy findings available				
COT te law te has te bas te ge 2 sh	du			autopsy	ned? death?	mpletion of cause of				
		25. Was case referred to medical	26.Place of Death (Chec	1 ✓ Yes 2	No 1 ✓ Yes	2 No				
Division of Vital the Haspital or Attending Physician: hin 24 hours after death. the Funeral Directur: After this certifuletely filled in by the funeral director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nurs	sing Home 5 R	tesidence 6 Other:					
n of Jing P After funera		27. Manner of Death 1 Natural 5 Pending Jul Month, pay, Yaar) 28a. Date of Injury Jul Month, pay, Yaar) 0800 hrs		28d. Describe ho Subject drow	ow injury occurred					
Division tal or Attendi rs after death. al Director: /	cati	2 Accident Investigation	1 Yes 2 ✓ No							
Divis pital or At ours after d teral Direct filled in by	Certification:	Suicide 6 Could not be determined (Specify) Bay	nory, onice building, etc.	or Town, Sta	reet and Number or Rura ate) e Parkway, Annapolis					
Haspi 24 hou Funer rely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	ut the time, date and place, ar							
Divisic To the Huspital or Atte within 24 hours after des Th the Funeral Directn completely filled in by th	Medical	one) 2 Medicai Examiner: On the basis of examination and/or investigation, i								
1	Σ	29b. Signature and title of certifier	29d. Date signed (Mont	h, Day, Year)						
2 gm		U-~U	O.C.M.E.		July 5, 2011					
0		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W.	Baltimore Street, Balti	imore, MD 212	23					
St	ate	31. Date filed (Month, Day, Year) 32, Registrar's Signature	, , ,		····					
Regist	rar	JUL 1 2 2011 Lever S. Jacks								
DHMH 17 Rev 1/20 OCME 2006	001	ORIGINAL								

OCME

Maryland 21215-0036 Baltimore, Box 68760 P.O. Records, of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, 2011 William Austin Kugler 6:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Montgomery Hospice Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Days Mar 14, Hours Year 929 Massachusetts Director 82 003-16-9189 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6924 Woodside Place 20815 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 XMarried 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 1951-1953 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Federal Government Economist 1 and 2 should be filed with the stand Mental Hygien item 27 is marked other 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other 27 is marked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Alexander Kugler Louise Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan G. Kugler / Wife 6924 Woodside Place Chevy Chase, MD 20815 Department of Health Important: If item 2: any injury or other t other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 7/12/2011 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sinus Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ending physician and use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ō Day Pregnant at time of death Month Year should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛮 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of has performed? Yes 2 X No The death? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🔀 No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ♣ Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natura 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063195 July 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0/

Registrar

DHMH 17 Rev 7/2009

Division

Rockville, MD 20855

Steven Wilks 6001 Muncaster Mill Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Shirley J. Kienle 3:45P 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Hospice at North West Hospital Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Hours Feb. 23, Min ^{Yea}1957 Baltimore, MD 54 Director 220-48-1406 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No MD Baltimore Owings Mills 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11940 21117 USA Park Heights Ave. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? 1 Pes 2 No Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Supervisor School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ၉ Weldon Preston Hale Norma Jean Wertz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 11940 Park Heights Ave. Owings Mills, MD 21117 Joseph A. Kienle/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Druid Ridge
Cemetery 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State Baltimore, MD Donation 5 Other (Specify) Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Part 1. Enter the disclase, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Caule (Final overian CLINCER Pnysician/ disease or con ition resulting in death Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events southing in deeth). Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phys the c nding p IF FEMALE: 23c. If yes, outcome of pregnancy use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 🗆 No 1 🗌 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🖭 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this leted filled in by the funeral directed directed and directed after the second seco 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number MSRyapalnem.D D0057 465

DHMH 17 Rev 7/2009

Registrar

Smith AV

2835

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-5-Rajapaksemo

31. Date filed (Month, Day, Year)

JUL 1 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 011 Physician/ July 9, 6:50 A M Charles Joseph Koerner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 331 Layton Rd. Reisterstown 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year far 9 , 1 9. Birthplace (State or Foreign **Funeral** Months Davs Hours **X**XM 2 □ F Marvland Director 212-34-0673 75 936 lar. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Reisterstown 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Funeral 23a 331 Layton Rd. 21136 U.S.A. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
XIXYes 2 \(\subseteq \text{No } 1961 Black, White, etc. ò þ 1 Never Married 2X Married $har(es) \qquad har(es)$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 📉 o Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1996 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) U.S. Pôstal Service Letter Carrier is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anna Senft George Koerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Son 331 Layton Rd. Reisterstown, MD 21136 Anthony Koerner / 20a, Method of Disposition 20b. Place of Disposition (Name of Garrison Forest Veterans Cemetery XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/13/11 Owings Mills, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fandal S 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e.g. line. Approximate Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Other (specify) the Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I page 2 s performed this certificate 1 ☐ Yes 2 ☑ No Yes 2 🐱 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ည ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27, Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie In cause of death (Item, 23a) (Type, Print) of person who completed 30. Name and address Baltimore Maryland Avenue 31. Date filed (Month, Day, Year Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JOSEPh-Lee KITTRELL Physician/ Month - 207 M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fulton 7549 Cherry Tree Drive Howard Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country Virginia 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Dec. 1 Day, 1919 Months Hours Min. 230-07-1947 91 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Fullton 1 Yes 2 X No Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20759 7549 Cherry Tree Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Scientific Instrument Maker Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Myra Bernice Whitehurst Joseph Lee Kittrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Z. Kittrell/Wife 7549 Cherry Tree Drive, Fulton, Maryland 20759 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parklawn Memorial Parklawn Memorial Park 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Emeral Service Licenses M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ STROKE One weak disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Ordenying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) nding physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant 5 Other (specify) Month Day Year Pregnant at time of death detached g signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? POTHYROIDISM 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 has page 2 certificate 1 Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 24 hours after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D. 30469 July

Registrar

DHMH 17 Rev 7/2009

State

COLUMBIA

Registrar's Sign

100 PARKWAY, \$308,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2 2011

Date filed (Month, Day, Year)

8850

Columbia MD-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June 2011 7:05 PΜ James Kimes Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min North Carolina **Director** 86 229**-**16-6315 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 1115 Quantrill Way 21205 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 🕅 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Loila Trail D.L. Kimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Clark - friend 1056 Quantrill Way; Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 █ Other (Specify) in state cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metastatic Onset and Death Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that in tisted even to the conditions). Examine Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death Month Year signed by the a d be detached for Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pulmonary Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2/2 this certificate 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after de To the Funeral Director completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-30-2011 MD

State Registrar

31. Date filed (Month, Day, Year)

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Falls

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Registrar's Signature

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Baltomore

21209

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yolk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 JULY 7:05 AM BESSIE V. KING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS ELDERCARE HERITAGE CENTER BALTIMORE DUNDALK 1 Year If Under 24 Hrs g. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕱 Months Days Hours Min. 8454 7975 MARYLAND 220-14-7793 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location Director 1 Yes 2 No N/A BALTIMORE CITY MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 1521 RAMBLEWOOD ROAD 21239 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐Xio Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHTTE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) DEPARTMENT STORE SALES PERSON 9TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ THOMAS PAUL TANKERSLEY HAZEL E. HUBBARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5606 BURKETTSVILLE RD. JEFFERSON, MD THOMAS TANKERSLEY/NEPHEW Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/12/2011 CATONSVILLE, MD METRO CREMATORY, INC. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO2 17 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SPIRATOR Priysician/ Medical Due to (or as a consequence of): Examiner LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-trans Due to (or as a consequence of AMXIE Physician/Medical Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 2 No 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 2 No 1 Tyes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Contifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar Marke

1- Place Dundalk MD 21222

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	iarylan		artment of I		and Men	tal Hyg	jiene				
			State Registrar		Certificate of Death						Reg. No		22099		
	Physicia	n/	Decedent's Name (First, Middle, Last	Salvese						Date of Deat Month	Day 7	Year	3. Time of Death 11:30 A ^M		
بالمر	Medic	al	Christian 4a. Facility Name (if not institution, give	n	n Led1ey 4b, City, Town, or Location of Death					1 2017					
	Examin	er	13108 Venetian F					er Sp				Montgo			
	Funeral		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. Ia	ast birthday)	If Under 1 Year	If Under	24 Hrs. 8, E	Date of Birth	1	9. Birtl	hplace (State or Foreign		
	Director		331-34-0843	□ M 2 X X F	85	Yrs.	Months Days	Hours	Min. Au	Month, Day,	Year) 25	Sc	otland		
	d ow t	_	Usual Residence of Decedent 10a. State 10b. County		T 10c Cits	v. Town or Lo	ation						10d. Inside City Limits		
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	or 28		10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			10f. Zip Code	1			10g. Citizer	n of What Cou	untry?		
	with t	Funeral	13108 Venetian H	ld.			2	20904			Uni	United States			
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent Armed Forces?		13. \	Vas Decedent of H	lispanic Orig	gin? (Specify \	Yes or No-	14.	Race - Amer Black, White			
36	after of ", or camir	<u>a</u>	1 Never Married 2 Married	1 ☐ Yes 2 🗓 If Yes, Give		- I	☐ Yes 2 🔀 No				Spe		White		
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pu	以子事を	To Be	17. Father's Name (First, Middle, Last)		177	112-4		l	,	st, Middle, f		salvesen			
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Maryland 21215-0036	2 sh thar thar trau		19a. Informant's Name/Relationship (7) Jean Jarman / Dat			19b. Mailing Address (Street and Number or Rural Route Number, City or 13114 Venetian Rd., Silver Sprin									
ē,	and Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of		Date	1		tion - City or	Town, State		
mo	0		1 ☐ Burial 2 🔯 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				natory or other pla ce Cremat		07/11/	2011	Ве	ltsvi]	lle, MD		
Baltimore,	permit. Page Department Important; I any injury o	П	21. Signature of Funeral Service Licen		mcc382 22 Name and Address of Facility Rapp Funeral and 933 Gist Ave., Si						n Sar	wices			
<u>m</u>	9 9 2 8 9	1	Though Xot	man	-		933 Gist	Ave.,	Silve	r Spr	ing,	MD 2	20910		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o			h. Do not ente	er the mode of dyi	ng, such as	cardiac or res	piratory arre	est,		Approximate Interval Between		
ď	Priysician/		Immediate Cause (Final disease or condition	a		AL INFAR	CTION					1 HOUR			
mark	Medical Examiner		resulting in death)	Due to (or as			ם מכול בינו	7 T C TF A C	717				5 YEARS		
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Box 687	ath ce attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live Birth	2 Feta	al death 3	eath 3 Ectopic pregnancy					23d. Date of delivery Month Day Year			
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P.O.	Attending Physician: The law requires that the death certificare death. ector: After this certificate has been signed by the attending is by the funeral director, page 2 should be detached for use as by the funeral director.		Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying cause g	iven in Part	I.	23e. Did to	bacco use	contribute to	the cause of death?		
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tal	ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?	Hospital:					ith (Check only	one)					
ſΖ	Physi this c	은	1 ☐ Yes 2XXNo 27. Manner of Death	1 ∐ Inpa		ER/Outpatie		4 ∐ Ni		Home XX Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
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isio	l or Attendatter deat Director:	Certificate:	3 Suicide 6 Could not be determined	28e, Place of In			eet, factory, office		28f.	28f. Location (Street and Number or Rural Route Number,					
Division of Vital Records,	salor safte		1 I I I I I I I I I I I I I I I I I I I	building, e	tc. (Specif)	/)				City or Tow	n, State)				
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			29b. Signature and title of certifier	1 0			29c. Licens			1		signed <i>(Month</i> LY 8,			
	10 %		30. Name and address of person who	Strk	death /lten	1 23a) (Time I		9748			301				
	,		ALAN WEINSTOCK M	.D., 1031	3 GEO	RGIA A	VE #105,	SILV	ER SPR	ING, 1	MD 20	0902			
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	tra's Signa	fire del									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death nt's Name (First, Middle, Last) 3. Time of Death Physician/ Logan ilton 2011 3:58 AM Medical give s Examiner or Location of Death 4c. County of Death more tospice Ba If Under 24 Hrs. 8. Date of Birth
(Nort) 9ay, 1923 **Funeral** 9. Birthplace (State or Foreign 1 M 2 🗆 F Months Hours Min. Country) D Director Usual Residence of Decedent s 23a or 28a-f show lust be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

That If free at the Mental Hyglene. That If free 23a or 28a-f sho individual to other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, 10b. County 10a. State City, Town or Location Completed by Funeral Director 10d. Inside City Limits fimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid ပ 19a, Informant's Name/Relationship (Type, Print) (Sister and Number or Rural Poute Num vn. State, Zip Code) MD 21223 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troops. enace of Disposition (Name of cemetery, crematory or other of 20a. Method of Disposition 20b. Place of Dispa 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the shock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TRO disease or condition WEEH / Medical resulting in death) Due to (or as a consequence of) Examiner PENIPHER ASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Year Pregnant at time of death Other (specify) Month Day Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by T); / +cn Logan Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 🗌 No 1 Tyes e Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certific 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Cother (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LENG 4NAN 821 N.EUTAW 57 4 305 31. Date filed (Mont 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ Day 201^{Year} Towanda Renee Lucas 1:57 9 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 1 M 2 TF Days Min Yrs Director 217-78-6551 MD 0 - 11 - 1960Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director notified N/A MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 23a Funeral 21206 USA 4617 Luerssen Ave. death v items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the MALL. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No Specify:Black If Yes, Give Year or Dates 1 Yes 2X No Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hair Cuttery Cosmetologist N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Feaster Lawrence Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luerssen Ave. Baltimore, MD 21206 4617 <u> Terrv Lucas- Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other
King Mem. Par 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-16-2011 Randallstown, MD Park 21. Signature of Fun ral Service Licensee March F/H 1101 E. 22. Name and Address of Facility MD 21202 Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CNSTLLAR disease or condition MONTHS **▶** Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impuly that initiated events resulting in death) Last Due to (or as a consequence of): Exami the burial-transit and Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year Yes 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner Other: 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Oother (Specify) Hospic 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MIC 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

APATHI

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NORTH

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201 Year July John Louis Lamb, Sr. 8:30 PM 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6817 Dunbar Road Dunda1k Baltimore Co. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** nth, Day, Year) 925 Months Days Hours Mir 1 X M 2 - F Maryland 85 Vrs 220-18-5754 Director Usual Residence of Decedent 10b County 10a. State 10c. City. Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 ☐ Yes 2 🏝 No MD Baltimore Dunda1k 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ö ms 23a or must be r Funeral 21222 740 Aldworth Road United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Year or Dates. WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Electric Motor than Elementary/Seconday (0-12) 8 Years n 27 is marked other than a 17 is marked other than er traumatic event, the M College (1-4 or 5+) Repairman Repair Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chauncey D. Lamb Helen A. Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 740 Aldworth Road Dundalk, MD 21222 19a. Informant's Name/Relationship (Type, Print) Lyattment of Health at.
Important: If item 27 is 1 any injury or other **
Once. Mrs. Selma D. Lamb (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7/9/2011 Baltimore, Maryland Donation 5 Other (Specify) of Funeral Service Lice 21. Signati 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. <u>Dundalk</u>, <u>Maryland</u> Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ now disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atheroscleritic asidionisa Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Pregnant at time of death 2 No been signed by the a should be detached 9 Unknown 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diahetes Wellitos 1 ☐ Yes 2 ☐ No 3 2 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? Mease Hzheimer 24a. Was an has page 2 autopsy performed? 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 ☐ Yes 2X No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) , 2011) 396600

DHMH 17 Rev 7/2009

State Registrar Bultimer

30r Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1566

North

32. Registrar's Signature

11-04994 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Virginia Lambert Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day July 4, 2011 Medical Examiner Virginia Lambert 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months **Director** Days Hours 47 2 X F 1 M Nov. 26, 1963 236-11-7754 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other thao "oatural", or items 23a or 28a-f show iojury or other traumatic evect, <u>the Medical Examioer must be ootified at ooce</u>. MD Baltimore Dundalk 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
item 27 is marked other than "oatural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 8255 Kavanagh Road 21222 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: 合 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Waitress 17. Father's Name (First, Middle, Last) æ Allen Richards Goldie Kane 19a. Informant's Name/Relationship (Type, Print) John E. Lambert - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State crematory or other place) Pages 1 Oak Lawn Cemetery 7-9-2011 Domation Other Specify: uneral Service License **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Medical a Ruptured Myocardial Infarction Examiner or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit law requires that the death certificate be executed ᇙ UNPENDED AMENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? 2 Pregnant at time of death 5 Other (Specify) has been signed by the att 1 Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Chronic Obstructive Pulmonary Disease Completed certificate page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner?

10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indien, Black, White, etc. Specify: White 16b. Kind of Business/Industry Food 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8255 Kavanagh Rd., Dundalk, MD 21222 20c. Location - City or Town, State Essex, MD 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur SPring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ✔ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 2 🗆 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Pending 1 Yes 2 No Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 5, 2011 30. Name end address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL** DOME

Time of Death

1336 hrs

4c. County of Death

N/A

Foreign Country)

DHMH 17 Rev 1/2001 **OCME 2006**

✓ Yes

Accident

Suicide

Homicide

1 V Natural

2

g

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 PM Medical Eacility Name (if not institution, give street and number, **Examiner** 4b. City, wn, or Location inty of Death ltmare If Under 24 Hrs. 8. Date of Birth If Unde 9. Birthplace (State or Foreign Security Number Age (In vrs. last birthday) **Funeral** Min nth, Day, 1 - M 2 X F **T**931 229-36-3457 **Director** 80 Yrs. New Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 🄀 No Catonsville Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 6435 Clifton Forge Circle 21228 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martin Hiza Reubena Howie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6435 Clifton Forge Circle Catonsville, Maryland 21228 Richard T. Lockie, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 07/11/11 Baltimore, Maryland Crematory Inc. Metro 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Signature of Funeral Service Licensee Thomas Gregor Romai 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical Due to or as resulting in death) a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the a tending physician to be detached for use as the buria Physician/Medical dea h certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Detail death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Yes b Hosoital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the part of the principle of the princip Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 2 🗌 No 1 Yes 25. Was case referred to medical inpatier funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 240 ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation completed filled in by the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 only one 29b. Signature and title 29d. Date signed (Month, Day, Year) of dea (Item 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 7/2009

State

Registrar

(Month, Day,

1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Finsure All Copies Are Legible. amend #10ex 19b per Fil Ggl, Indelible Ink. Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 48 Physician/ ANNE 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWART (OO) N M 8. Date of Birth (Month, Day Year) Aug. 19,1940 If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country)
Washington, D. If Under 1 Year 7. Age (In yrs. last birthday) Social Security Number 6. Sex Funeral 1 □ M 2 1 F Months Days 70 Director 579-52-2971 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland anent of Heatilth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", and the traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 🗌 Yes 2 🏿 No MD Howard Columbia 10e. Street and Number **Eliots** 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 5188 Oak Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 K No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2K No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Housing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Helen Elizabeth Jones Eugene Bernard Gorrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5188 Eliliott Oak Road Columbia, MD 21044 19a. Informant's Name/Relationship (Type, Print) Amy Murray (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7-10-2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Witzke Funeral Homes, Inc Road Columbia, MD 21045 22. Name and Address of Facility Inc. 5555 Twin Knolls Road Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) NEUMONIA Examiner N(Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ne Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate I 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital director, Be examiner? Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Hatural 5 Pending Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANG, COLOMBIA, MI AN MURU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2 2011 park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last). Month Physician/ 12:40AM ATHERINS Medical 4c. County 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death of Deat **Examiner** P BURNI GLSN 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Mar. 19 Days Year 1923 Mary Land 1 □ M 2 💢 F 217-16-4033 88 Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 XNo Maryland | Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 2360 Fleagle Rd. 21061 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Print Circuit Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Voelkel Viola Mummert 19b Northing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2360 Fleagle Rd., Glen Burnie, Maryland 21061 19a. Informant's Name/Relationship (Type, Print) / Son Francis E. Lambert, Jr. Baltimore, 20a. Method of Disposition ly 13, 2011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ju1v 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Glen Haven Mem. Pk. onation 5 Other (Specify) Glen Burnie, Maryland 4 🗆 e of Fund al Serv 2, Name and Address of Facility
irkley-Ruddick Funeral Home, P.A.
21 Crain Hwy., S.E., Glen Burnie, Licerse 21. Signat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMER DEMEN Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ģ Month Day Year Pregnant at time of death hed g 🗌 Unknown 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) in by the funeral director, examiner? Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide within 24 hours aff

To the Funeral Di

completed filled in Medical 1-X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ٥ 10002915 empleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 1 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EITCH 320 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Hospice of the Chesapeake Linthicum Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Dec Month, Day 1952 Maryland 58 Director 220-56-8636 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tyes 2 No Galesville Anne Arundel MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 20765 1001 E. Benning Rd. death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after white 1 Yes 2 X No Specify: If Yes, Give 3 Wildowed 4 Noivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 clerk permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hilda Marie Miller Dudley Hill Leitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Hines - friend 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board ral Survice Licer aniel K. Naylor 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final ESOPHIA Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Que to for as a nonsequence of: cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed and -trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Other (specify) the 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 1 Yes 2 1110 ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of PICE 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No +ouse Accident Investigation ☐ Accide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Destrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 118703 201 DI ted cause of death (Irem 23a) (Type, Print) 445 DEFENSE HWY, AMPAPOLIS, MD. ZIKOL IGHTF001 VEUCUE 31. Date filed (Month, Day, Year, 2. Registrar's Signature State 12

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 2917 7-12-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:30 PM LE MA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harbor Hospital N/A Baltimore Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, Year) -b 5 1920 Days 1 🔀 M 2 🗆 F Director 91 Kentucky 400-07-8177 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Anne Arundel Brooklyn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21225 4211 Ritchie Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 9 1 Never Married 2 K Married 1 X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked ot ٩ Parson Maxie John Lemaster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4211 Ritchie Highway Brooklyn, MD. 21225 Stella T. Lemaster/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD. 7-14-11 Greek Orthodox Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. . Signature of Furral Servic / Licenge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit requires that the death certificate be executed and that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnan Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown s been signed by the s should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2-No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The law page 2 performed? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 욘 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending work? 1 🗌 Yes 2 🔲 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of -201 Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlos Patalinghug Sr. 3721 Potee St. Baltimore, Md. 21225 State Registrar

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Physicia	n/	1. Decedent's Name		•						2. Date of De		ay Year	3. Time of Death
Medic		Marie Ro								July 10	1	011	3:15 P M
Examin	er	4a. Facility Name (if		ve street and numb	er)		4b. City, Town, o	r Location	of Death		1	C. County of Dear	
Funeral		Gilchris 5. Social Security N		Sex 7	. Age (In yrs. I	ast birthday)	If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Birl		Baltimon g. Bir	thplace (State or Foreign
Director		214-24-56	773	1 □ M 2 X X F		83 Yrs.	Months Days	Hours	Min.	10719		7 Mar	y land
nd how	'n	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Aarylai 8a-f s tified	Funeral Director	Maryland	Baltimo	ore	Lu	thervi	11e						1 ☐ Yes 2 🕻 No
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or iter	by Fu	11. Marital Status 1 Never Marr	ied 2 🔀 Married	12. Was Deced Armed Ford	es?	If Yes, specify Cuban, Mexican, Puerto I				cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
ırs afte ıral", IExar		3 Widowed		If Yes, Give Year or Date		1	1 ☐ Yes 2 🛛 No	Specif	y:			Specify: Wh	ite
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Richard		/ Husban	d	1	ng Address (Street Branford						
of Her of Her if item		20a. Method of Disp		Removal from S		Place of Dispo	sition (Name of natory or other place	ce)		Date	20c. L	ocation - City or	Town, State
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permi Depar Impo any ir		21. Signature of Sur	noral Service Lice	all	Mi		2. Name and Addre 1050 York						ome, Inc. 204
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the at the at	Completed by Physician/Medical Examiner	1 Yes 2	No	4 ☐ Pregna 9 ☐ Unkno	ant at time of own	death 5	Other (specify)					Month	Day Year
that the decent	y Ph	Part II. Other signif	ficant conditions	contributing to dea	ath but not res	sulting in the u	ınderlying cause gi	ven in Par	t I.	23e. Did to	obacco	use contribute to	the cause of death?
v requires the speed signers should be a	ted k									1 🗆	Yes 2	No 3 □ P	Probably 4 🗆 Unknown
law rei nas be e 2 sho	nple									24a. Was autor	osy	prior to	itopsy findings available completion of cause of
Physician: The law rthis certificate has traid director, page 2 s		05.141	- d t d: l							1 L Yes	rmed?	death?	s 2 🗆 No
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or Attending Ph after death. Director: After th in by the funeral	Certificate:	1 Natural 2 Accident 3 Suicide	Investigati	on be			M 1 🗆	Yes 2	\rightarrow				
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check		nysician; To the beaminer: On the basis									ated. cause(s) and manner stated
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'		30. Name and address	ess of person who	completed cause	of death (Iten	n 23a) (Type, F	Print)	Mad	2160	100	<u></u>	lly (1	1101
01-		31. Date filed (Mont.	h Day Yearl	WATER SO BOY	gistrar's Igna	ture =	OL N	Cre	vel	51	(0)	1030/	
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JulyDoris Α. Lewis 2:05 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Multi Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign **Funeral** Days Months Mary Land 1 □ M 2 🗓 F Director 217-22-9879 91 Nov. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore Baltimore 1 🗌 Yes 2 🛣 No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Rossville Blvd. 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Amelia Hladik Alonzo Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3204 Tally Ho Place Fallston, MD. 21047 Bonnie Adamiak Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) Bohemian Nat. Cem. 7-14-11 Baltimore, MD. ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 21. Signature of Juneral Service Lice 23a. Part 1. Enter the visease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Onset and Death Immediate Cause (Final EMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or imjury that initiated events Due to (or as a consequence of) as the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death g 🗌 Unknown þ funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending injury 2 🗌 No Investigation Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly one 29b 29c. License number 29d. Date signed (Month, Day, Year) signature an D0060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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1 PN rr,
31. Date filed (Moph, Day, Year)

11-05022	
Dennis Moore	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ennis Moore	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	2111							
Physician Medical Examine									
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital 4c. County of Death N/	A							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State 20 - 90 - 2577 1 N 2 F 33 Yrs. Months Days Hours Min. 4/23/1978 Foreign Country)								
any	Usual Residence of Decedent	le City Limits							
E	MD N/A Baltimore	s 2 No							
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Dennis E. Moore, Sr. Theresa Smith								
MD 2. 12 should th and M 27 is m umatic e	19a. Informant's Name/Relationship (Type, Print) Theresa Smith- Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62l E. 37th St. Balto., MD 21218	1							
Baltimore, MD permit. Pages I and 2 shc permit. Pages I and 2 shc peparment of Health and important: If item 27 is injury or other traumati	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, prematory or other place) King Mem. Park 7/13/201 Randallstown	n, MD							
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. Nor Ave. Baltimore, MD 21202								
Physician /Medical !xaminer	failure. List only one cause on each line. Immediate Cause (Final disease e. Heroin and Alcohol Intoxication	mate Interval n Onset and Death							
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	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
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Box 68761 e death certificate the attending phy ed for use as the by	Part II. Other significant conditions Part II. Part	Year							
F. P.O. I ires that the signed by till be detache	1 Yes 2 No 3 Probably 4	_							
Division of Vital Records, P.O. Box 68760, In the Hospital nr Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transpotical Contributed by Dhusician Madical Expedices of the contributed by Dhusician Madical Expedices.	24a. Was an autopsy finding autopsy performed? 1 V Yes 2 No 1 Yes 2	of cause of							
Vital hysician: this certif	25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) Continuous Place of Death (Check only one)								
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Division To the Hospital ar Attend within 24 hours after death. To the Funeral Directur: completely filled in by the	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
Ta wii I	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ear)							
	30. Name and ad fress of person who completed cause of death (Item 23a)								
Stat	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Stat Registra	IIII A A AAAA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For Amend Item 28b Per me, g917,07/12/2011 dnb
Registrar Certificate of Death
Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month mcNemar 25, 2011 am 12:50 Ann June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner monthouser Suber bon Hospatal Bathosda 5. Social Security No 295 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country)
Ohio **Funeral** Months Days Hours Min 05/09/1945 1 M 2 K 291 - 42 - 92Yrs. 66 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Md. Montgomery Bethesda 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 7903 Kentucky Ave. 20814 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 'natural", Specify. 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Practioner NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert McNemar Katherine Hunt traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Cynthia M. McNemar(Niece) 3320 Mill Dale Lane New Windsor,Md. 21776 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date All County Cremation 06/28/2011 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Md. ^{22. Name and Address of Facility} Haight Funeral Home & Chapel P.O. Box 195 Sykesville,Md. 21784. 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Brain Injury disease or condition Medical Examiner resulting in death) ull Fracture Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine accidential Fall burial-transi 286 , P.O. Box 68760 nding physician ause as the burial-Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ō Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy Yes 2 certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatie<u>nt 2 ☐ ER/Outpatient 3 ☐ DOA</u> ည this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 🔀 No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural
2 Accident 5 Pending 12.10 P M stairs down 24 hours after death Funeral Director: A Investigation 6-24-11 filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 7903 Kentucky Ave, Bethesda MD Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only on within 2 3 and title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year) 6.28.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 420 Rockledge Dr. Suite 2200 Bethesda MD 20817 Enique Daza MD State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{ ext{Month}}{ ext{July}}$ Physician/ 2011 **11:**25 P^M Robert Lee McClary Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 1528 Nicolay Way Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Dec 10, 1933 Maryland 215-30-4916 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 XNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA 1528 Nicolay Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Divorced 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 10 College (1-4 or 5+) Service Manager Used Parts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Edward McClary Mary Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1528 Nicolay Way Essex, Maryland 21221 JeanAnne McClary, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 07/08/11 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Lice Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 [⊕]Thomas Gregor 23a. Part 1. Enter the disease or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 24 hours after death.

2 Funeral Director: After this certificate I leted filled in by the funeral director, pagr ROBERT 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 29b. Signature ar 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ·ha Physician/ na che o Pay 16/6/M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 150 timere Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Days Months Hours Min. Sept. 24, Yea 1941 New York Director 111-30-1820 69 Usual Residence of Decedent permit. Page 1 and 2 should be fired writting it a more and and 28 and 28 and 28 and 28 and Important: If item 27 is marked other than "natural", or items 28 and 28 and 5 show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code Funeral USA 21210 200 Cross Keys Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 KNo Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry National Football Elementary/Seconday (0-12) College (1-4 or 5+) **Athlete** 4 League Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dora Hill ပ္ Walter Mackey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Cross Keys Road, Baltimore, Maryland 21210 Svlvia C. Mackey Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Glen Burnie, Maryland 7/10/2011 Atlantic Crematory Signatur Fyneral Service License 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enje the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ try disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): use as the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d mellits 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed' death? 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Pother (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 Yes 2 No Accident Investigation I hours after death uneral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of cert 29d. Date signed (Month. Day. Year) 00051189 82 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5005 21224 filed (Month, Day, Yea JL 1 2 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:30P M 8 ay Physician/ July 20°11 Nicholas J. Mansfield Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Sparks Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number .Sex 1 M 2 □ F 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 0(Month, 176y, Year) 922 Furton, NY 059-18-1383 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 🗆 Yes 2 🛣 No MD Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21152 1936 Akehurst Road er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ⚠ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Container Corp. Plant Superintendent permit. Page 1 and 2 should be filled wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other transact Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Marion Haskins Nicholas W. Mansfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1936 Akehurst Road MD 21152 Sandra L. Mansfield/Wife Sparks, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oulaney Valley Memorial 7/19/11
Gardens 1X Burial 2 Cremation 3 Removal from State Timonium, MD Donation 5 Other (Specify) Signature of Pontral Service Licensee Bryan W. Clary 22. Name and Address of Facilit Lemmon Funeral Home of Dulaney Val 10 West Padonia Road Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final MESOTHEllomA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifical Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 - Nursing Home 5 - Residence 6 A Other (Specify) 105 A 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Investigation filled in by the Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20836 Zel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 N. Charles ST touson Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

1 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2011 5

		•	State Registrar		,	Cer	tificate of l	Death			Reg. N	No.	
Т	Dhuaisia	- (1. Decedent's Name (First, Middle, I	.ast)						2. Date of De	ath		3. Time of Death
ı	Physicia Medic		Robert W.		Sr.					July	8,	^{Day} 2011 ^{Year}	4:40 P M
~	Examin	er	4a. Facility Name (if not institution, g				4b. City, Town, o			4	4c. County of Death Baltimore		
المعبدية ا		Ш	Gilchrist H 5. Social Security Number 6		(In yrs. last	hirthday	If Under 1 Year	OWSO		8. Date of Bir	th.		hplace (State or Foreign
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	the A	اق	10e. Street and Number				10f. Zip Code				10g.	Citizen of What Co	untry?
	n with	Funeral Director	220 Walgrov	e Rd.				2113	6			U.S.A	A •
	r item		11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes XXI	ver in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Or an, Mexica	rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Amer Black, White	
Baltimore, Maryland 21215-0036	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 ☐ Marrie	1 ☐ Yes 🔏 🔏 If Yes, Give Year or Dates.	If Yes, Give Year or Dates.		1 ☐ Yes XX No Specify:						nite
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Ba	permit, Page 1 Department of I Important: If it any injury or or once.		21. Signature of Funda Service Lic	Ann		1 1	. Name and Addre	ss of Facil	stow	narut n Rd.	ru Owi	nerar ci ings Mil	1s,MD21117
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S, P	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completed filled in by the funeral director, page 2 should be detached for use	d by	PULMONARY			ng in the d	nderlying educe gr	voiriiri di					robably 4 Unknown
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	Vitl To		29b. Signature and title of certifier	1	1		29c. Licens	e number			29d. [Date signed (Month	, Day, Year)
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	1 0.		30. Name and address of person wh	o completed cause of de	eath (Item 23	sa) (Type, P	INCh	10,0	C STO	eer B	0	n A	1021704
	Stat	е	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	0/01	10/011	IF W.	JUIFE	- 1 11	14.	IMUET	VUICOT
	Registra		.111 122	011 6	1	1.							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ July Joseph T. Maher, Sr. 8. 2:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 220 Central Ave. Baltimore G1yndon If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Sep. 14 9. Birthplace (State or Foreign . Age (In yrs, last birthday) **Funeral** 1**X**XM 2 □ F Months Days Hours 80 930Pennsylvania Director Yrs 183-22-3368 Sep. Usual Residence of Decedent 28a-f shov aţ 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes X X No MD Baltimore Glyndon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Central Ave. 21071 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? XXX Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married ģ Saltimore, Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes XX No Specify. White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Systems Administrator Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Thomas Maher Dorothy E. Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glyndon, MD 21071 220 Central Ave. / Wife Lynne S. Maher thod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/12/11 Owings Mills, MD Garrison Forest Cem. 21. Signature of Fur eral Se Se Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ OBSTRUCTIVE MODIC Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: Exami The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pi IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Pregnant at time of death 2 No a Unknown 9 Unknown signed by t i be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been sign e 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
☐ Yes 2 No page death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No Hospital Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d, Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be within 24 hours after death To the Funeral Director; completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check g Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certify only one 29b. Signature and the 29d. Date signed (Month, Day, Year) NICK MELLIS MD 00047742 8 8%

Registrar

State

31. Date filed (Mont

IMONIUM, MD 21093

NICKMELLIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 11,12,15–22 per 1h g917 7–12–11 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Moore 201 Prox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** orest Haven Catonsville Baitimore Nursing Home MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 D F Social Security Number 7. Age (In yrs. last birthday) Funeral March, Day Year) 1936 Days Min. Months Hours 219-32-3236 75 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Catonsville MD Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21228 USA Funeral or items 23a 701 Edmondson Ave death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status +111k Black, White, etc. black 1 Never Married 2 Married þ 2 🗷 No 1 Yes If Yes, Give 72 hours after 1 Yes 2 No Specify: Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupatio 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) -unk ပ္ Hattie Mae Williams Levi Moore 19b. Mattin 2 three land Number of Route Number City or Town, State, Zip Code)

5220 York Rd; Baltimore, Maryland 21212 a, Informant's Name/Relationship (Type, Print) **Hattie Moore** Treida Jones - legal 21206 legal guardian Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1 ☐ SE8 + C cemetery, crematory or other place) On Site Cremation 7-12-11 Baltimore, Md. Tuver la vings on Name and Address of Facility State Apatomy Board Gilmor St. 655 W. Baltimore St; Baltimore, MD 2120121217 21. Signature / Funeral Service Licensee. Cen 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final a Atherosclerefic disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pt IE EEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No the detached g Unknown 9 Unknown Division of Vital Records, P.O. ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed lector, page 2 should be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has it completed filled in by the funeral director, page 2.8 autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27 Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending М ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Broatin Klacon D15503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 DOLPHIN STREET BALTIMORE IND MACEM 31. Date filed (Month, Day, Year) Registrar's Signa State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 25 1:10 PM M Kathryn B. Millings 2011 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7219 Park Heights Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 29, 1921 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2X F Months 215-22-0450 90 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Pikesville Director Baltimore 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 21208 USA 7219 Park Heights Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No ģ 3 X Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry J Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If tem 27 is marked other the any Injury or other traumatic event, Inc. once. education teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lemual Way Victoria Diggs ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keisha Hitch - niece 111 Westgate Way; Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Funeral Service Licensee Daniel A. May1 21. Signature 655 W. Baltimore St; Baltimore, MD 21201 (1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metosta disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) I□Yes 2□No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🗵 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

24 hours after deat Puneral Director: filled in by the cal To the I within 2

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Paul Place DWAN MARKIN

State

(Check only one)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Unde 8. Date of Birth Birthplace (State or Foreign Country) If Under 24 Hrs. vrs. last birthday) **Funeral X** M 2 □ F Months Days Hours Min Yrs Director Usual Reside show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No inda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8231 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. KORCA Specify: 3 🗌 Widowed 4 🗌 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ASKON 22. Name and Address of Vacility radle cad 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition METASTATIC Medical resulting in death) ue o (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? PEKLIPIDEMI 24a. Was an has page 2 autopsy performed' certificate 1 Yes Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manne Death Certificate: 28b. Time of 28c. Injury at 5 \square Pending Natura work? 2 🗆 No Accident Yes Investigation 3
Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2-29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 146360

State Regist<u>rar</u> nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGE SCOTT MONTGOMERY JR 21:16 M 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Baltimore, MI 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 X M 2 | F 38 Months Hours Min. Director 220-90-8490 8-16-1972 MARÝLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Completed by Funeral Director r 28a-f sh notified a N/A MD. BALTIMORE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 5300 LOCH RAVEN BLVD. 23a21239 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian er than "natural", or iter the Medical Examiner Armed Force 1 Never Married 2 Married Black White etc. Yes 2 X No If Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTIONS CLERK III STATE GOVERNMENT of Health and Mental Hygie item 27 is marked other other traumatic event, Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE S. MONTGOMERY SR. CONSTANCE TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONSTANCE MONTGOMERY (MOTHER) 1617 WOODBOURNE AVE. BALTIMORE, MARYLAND 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Buria 2 Cramation 3 Removal from State cemetery, crematory or other place) injury or 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 7-13-2011 BALTIMORE, MARYLAND . Signature of Emeral Service Licensee JONATHAN D. HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s, or heart failure. List only one cause on each line. Interval Between Onset and Death Immed e Cause (Final Physician/ Bilateral neumonio Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records F.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3

Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 XNo မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate; 28d. Describe how injury occurred injury ✓ Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Home Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOCO 07/05/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Baltimore az de Kochak

DHMH 17 Rev 7/2009

Registrar

11-04885	
Harvey Mickey	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

narvey Mickey		1- For State Registrar		ate of Maryla		partment <i>Certificate</i>			Mental	Hygie		Reg. No	20	Marga Data	2212
Physicia Medical Examin			MICKE	Y						M	ate of Dealorth ine 30,	ath Day	Year		3. Time of Death 2037 hrs
)		Johns Hopl	kins Hospit					o. City, Town, or Lo Baltimore						/A	
Funeral Director		5. Social Security N	-1628	6. Sex 1∑XM 2☐ F	7. Age (In yr	s. last birthday) Yrs.	Months Days Hours Min.			8. Date of Birth (MM/DD/YYYY) 9.			Foreia	hplace (State or number of MARYLAND)
d any		Usual Residence o	10b. County		- 1	ity, Town or Lo									10d. Inside City Limits
the Maryland a or 28a-f show	Director	MD • 10e. Street and Nu 201 N •		AVE APT		BALTIMO		10f. Zip Code 2122			1	0g. Cit	tizen of Wha	t Coun	1 X Yes 2 No
15-0036 filed within 72 hours after death with the Maryland I Hygiene. ed other than "natural", or items 23a or 28a-f abo	Funeral	11. Marital Status 1 Never Marrie 3 Widowed		1Yes	rces?	,	13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,				Yes or No ı, etc.)	es or No- 14. Race - American Indian Bla			
72 hours aft n "natural"	<u>a</u>		lucation (Spec	orced If Yes, Give Year or Dates: ify only highest grad College (1-	e completed)	16a. Deced	dent's	es 2 No s Usual Decupation t of working life. De	(Give kind o	of work d etired)	one	16b.	Specify: Kind of Busin		ACK
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical	9	—10— 17. Father's Name (First, Middle,	,		DI	SA	BLED 18.	Mother's Nar	me (First	Middle, M		ISABII Surname)	LIT	Y
212	Ī		me/Relationsh NE HOR'	KEY ip (Type, Print) FON (MOTHE)	R)	19b. Mail	ing A	ddress (Street ar	nd Number o	r Rural R	IE HO Route Num B BA	ber, C	ity or Town,	State, MAI	Zip Code) RYLAND 2122
re, s l and f Heal		4 Donation 5	Cremation	3 Removal fro	m State M'	o. Place of Disp crematory or T . ZION	ositio other C	n (Name of cemet place) EMETERY	ery, 7 —	Date 8-20	011	20c.	LOCATION - C	ity or T	own, State MARYLAND
Balt permit. Depart Import		21. Signature of Fur	neral Service	icensee JONAT	NO	1.1	72	1-27 N	MONDO	E CT	DA.	TOTAL	MODE	A.C.A.T	P.A.
Physician /Medical Łxaminer		failure. List only failure Cause (For condition resulting	inal disease	omplications that can n each line. a. Seizure Due to (or as a c	Disor	th. Do not enter	r the	mode of dying, suc	ch as cardiac	or respi	atory arre	est, sho	ock, or heart		Approximate Interval Between Onset and Death
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Division of To the Hospital or Attending PR within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification: T		Homicide Da. Certifier 1 Control Check only 2 M	ertifying Phys	ician: To the best o	examination a	lge, death occu	rred a	at the time, date ar in my opinion, dea	nd place, and	due to t	he cause(s) and	manner as s	stated.	ause(s)
D F F S OW	29	9b. Signature and tit	e of certifier	and manner state	ed.			29c. License nun O.C.M.E.	mber		7	29d. Da	ate signed (
		Melissa Brass	s of person wheell, MD	o completed cause of Assistant Medic	al Examir	ner 900 W	/. B	altimore Stree	t, Baltimo	re, MD	21223				
State Registra	31	. Date filed (Month	T'T'2	2011 32. Jegis	trar's Signatu	J. Za	M	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 7^{ay} July Myrtle 2019 Nannie Morris 7:34 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 200 Engle Ave. Aberdeen 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 M 2 XF Days Hours **Director** Yrs <u> 227-28-1835</u> 84 1/11/1926 Virginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3628 Conowingo Rd. 21154 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2x ☐ No Specify. Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Footwear <u>Laborer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ George Howk Sarah Wingate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda West / Daughter 200 Engle Ave, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State West Chester, 4 Donation 5 Other (Specify) Co. 7/9/2010 & Ferris Pennsylvania Signatur 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD . Part 1. Enter the disease shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death re. List only one cause on eachline Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes X No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical To the Hospital or Attending Physician: pleted filled in by the funeral director, Be 26. Place of Death (Check only one) 6 X outler Specific mant's Hospital Other 2X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exa (Check nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. st of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Certifying Nurse Practioner: To the 29b. Signature and title 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of

31. Date filed (Month, Day,

rson who completed cau

e of death (Item 23a) (Type, Print)

10mDO

Registrar's Signature

				State of Mar				-		jible.		
		•	For State Registrar	Otate of Mai		rtificate of			Reg. No. 2		22121	
	Di did	,	Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	1	3. Time of Death	
	Physicia Medio			ances	Newsome	T		July	8 ^{ay}	2011	11:15 AM	
	Examin	er	4a. Facility Name (if not institution, give Holy Cross Hospi	,			or Location of Death er Spring		4c. County	of Death	aru.	
-	Funeral		Social Security Number 6. Se	7. Age (//	n yrs. last birthday)	If Under 1 Year	Jf Under 24 Hrs.	8. Date of Birt	th		place (State or Foreign	
	Director		281-26-3/15	□ M 2 XIF 83	Yrs.	Months Days	Hours Min.	May 22	, ^{Year} 28	Count	bama	
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	cation				1	0d. Inside City Limits	
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	a or 2 be no	اق	10e. Street and Number			10f. Zip Code			10g. Citizen of		•	
	th with ms 23 must	Funeral Director	11506 Bucknell D		Line Inc.	209		United States				
(0	er dea or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.		
03	urs aft ural", Il Exal	ted t	3 ☐ Widowed 4 🏌 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🏋 No	Specify:		Specify	В	lack_	
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pu	filed y	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam					
ryla	uld be I Ment narke	ř	Sterling		wsome		Alberta			Heade		
Ma	I 2 shouth and 27 is a		19a. Informant's Name/Relationship (Tynthia A. Newso:			-	and Number or Run			State, Zip C 209 0		
Je,	of Head of Head fitem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pla	col	Date	20c. Location	- City or To	wn, State	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	1)	Chesapeal	ke Cremat	ory 07/1	.1/2011	Be1t	svill	e, MD	
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Box 6876	eath certifica attending p	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3		су			ate of delive		
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	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director. After this completed filled in by the funeral d	Medical	(Check 2 Medical Examin	ician: To the best of my ner: On the basis of exam e Practiens: To the bes	nination and/or invest	tigation, in my opini	on, death occurred a	t the time, date ar	nd place, and du	e to the cau	se(s) and manner stated.	
	V Vith con		29b. Signature and title of contifier			29c. Licens	e number 52571		29d. Date signe	d (Month, E		
	18W		30. Name and address of person who c				OAD, SILVI	ER SPRIN		209		
	Stat	.6	31 Date filed (Month Day Year)	20 Begietrer's	Cianatura							
Pitt	Registra		JUL 1 2 2011 A	32. Registrar's	parked							
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State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IRMA GENE NORMAN 07/06/2011 Medical 235 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Days Hours Min Director 426-88-3083 05/26/1944 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 X Yes 2 No MD Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 376 N. Summit Avenue, #002 20877 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc ŏ þ 1 X Never Married 2 Married Yes 2 XNo 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural", Completed Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant ⊥2th Federal Government Be event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment, Important: If item 27 is marriany injury or George Lee Pruitt Bessie Ruth Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Norman / brother 376 N. Summit Avenue, #002, Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation Sv 07/18/11 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one s that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ ischemic cardiomyonath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ancreatitis 3 de VS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir death certificate be executed burial-transi Cause (Disease or imputhat initiated events resulting in death) Last and Due to (or as a consequence of) anding physician are as the burial Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atter in the past 12 months?
1 ☐ Yes 2 ☑ No for Month Day Year Pregnant at time of death signed by the a P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hunknown Completed neec . Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law r within 24 hours after death. To the Funeral Director; After this certificate has b page 2 s performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖫 No ပ 1 Mainpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 70144 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mike Murray, Rockville, Maryland 20450 1901 Medical Center Drive, 32. Registrar's State Registrar

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Z N Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•		ertificate of Death	Reg. No. 2011 22126
	Physicia		1. Decedent's Name (First, Middle, Last) Albert George Nickel, Sr.	2. Date of July	
,W,	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeral	-	2400 Lady Margaret Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Monkton // If Under 1 Year If Under 24 Hrs. 8. Date of	Baltimore f Birth 9. Birthplace (State or Foreign
	Director		196–10–8103	Months Days Hours Min. April	Pennsylvania
	and show	ē	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Maryl 28a-f	Jirec		t Hill	1 ☐ Yes 2 🕱 No
	h with the ns 23a or must be r	Funeral Director	10e. Street and Number 2423 Putman Road	10f. Zip Code 21050	10g. Citizen of What Country? United States
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	3 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes No Specify:	No- Black, White, etc. Specify: White
215-	72 ho an "nat Medica	Completed	(Specify only highest grade completed) (Giv	cedent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business Industry
	d withir ygjene her tha it, the	Be Co	10 College (1-4 of 5+)	hinist	Bethlehem Steel
Maryland	ld be filed Mental H arked ot atic even	To B	17. Father's Name (First, Middle, Last) Albert G. Nickel	18. Mother's Name (First, Mic Emma L. Frey	ddle, Maiden Surname)
	nd 2 shou ealth and m 27 is m			iiling Address (Street and Number or Rural Route Nu Lady Margaret Ct. Monkt	
Baltimore,	Page 1 a tment of H tant: If ite jury or otf		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Discernetery, or Sacred Hi	position (Name of rematory or other place) art of Jesus 2011	20c. Location - City or Town, State Dundalk, Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee Acom J Ly	Evans Funeral Chapel & (3 Newport Drive Forest B	Cremation Service-BelAir Hill, Maryland 21050
	Ph_sician/) Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac or respirator	Interval Between
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P.O.	es that the igned by be detact		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. [Did tobacco use contribute to the cause of death?
rds,	requires been sig should b	eted			Yes 2 No 3 Probably 4 Unknown
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Σ		은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		Residence State (Specify) Home
n of	tth.: After 1 funera	cate:	27. Manner of Death 1 Manual 5 Pending (Month, Day, Year) 28b. Time (Month, Day, Year)		be how injury occurred
Division	al or Atters after destable l'Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)
_	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director After this completed filled in by the funeral di	Medical	29a. Certifier (Check (Check only one) (1 Medical Examiner: On the basis of examination and/or involved only one) (1 Certifying Nurse Practioner: To the best of my knowledge.	estigation, in my opinion, death occurred at the time, d	ate and place, and due to the cause(s) and manner stated
	To the within comp		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)		Marlflwed us,	435522	July 11, 2011
2			30. Name and address of person who co-hipleted cause of death (Item 23a) (Type MARK WILD 2 NORTH AVE)	NUE BELAIR MAY	14 LANZ 21014
	Sta Registra	te ar	31. Date filed (Month Day Year) 2011 22. Registrar's Signature	Ves .	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BARBARA ILLION 424 7:13 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Gwynn Oak Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jul 12, **Funeral** If Under 1 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗙 F Months Min. Hours Country) Director Yrs 96 030-20-3580 191 Massachusetts Usual Residence of Deceden 28a-f show 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No MD Baltimore Gwynn Oak ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 6811 Campfield Rd 21207 United States filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 3 ed other event, th Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ pe ge 1 and 2 should be it of Health and Ments If item 27 is marked or other traumatic e George Thorley Magdalene D. Ferdinand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Pillion /Son Department of Healti Important: If item 2 any injury or other t 1502 Regester Ave. Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2. Cremation 3 ☐ Removal from State Jul 11 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives Ke Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus non each line. Approximate Interval Between Onset and Death Immediate Cause (Final +THEROSCLEROTIC REBROVASCUL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to minisulate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DISORDE Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen s 24a. Was an 24b. Were autopsy findings available Director: After this certificate has prior to completion of cause of death? autopsy perform 2 No 1 Yes 22 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated, 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) 28595 380 11 IVI Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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11-05096 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Curwin Sean Pilgrim State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Medical Examiner 1319 hrs July 8, 2011 Curwin Sean Pilgrim 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 5060 Kemslev Court **Baltimore County** Rosedale 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) Director -59-8151 1 M TRINIDAD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE ROSEDALE 1 Yes 2 No 28a-f show the Medical Examiner must be notified at once. **Itimore, MD 21215-0036**it. Pages I and 2 should be filed within 72 hours after death with the Maryland runent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 5060 KEMSLEV U.S.A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married Yes Specify: BLACK 3 Widowed Divorced If Yes. Give Year Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MANUFACTURING ENGINEER : If item 27 is marked other other traumatic event, the Me Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PilGRIM MICHAEL BRIT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2237 20b. Place of Disposition (Name of cemete/y, 20a. Method of Disposition 20c. Location - City of Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) ROODAL CEMETERY Donation 5 Other Specify. 2011 21. Signature of Funeral Service License 22. Name and Address of Facility DERRICKC 4611 PARK HEIGHTS AUE., BALTIMURE, MAR 23a. Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Subarachnoid Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Ruptured Berry Aneurysm Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and x AMENDED 18 per fh g917 7-15-11 vt UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? n 24 hours after death.

e Funeral Director: A letely filled in by the fur 1 V Natural 5 Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 (Check only 1 one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the I 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

rar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Carol Allan, MD

filed (M2th

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 9, 2011

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 12,20c per fh g917 7-12-11 yt State of Maryland / Department of Health and Mental Hygiene											
		•	1 - For State Registrar	State of Maryland /	Certificate of		Reg. 1	71111	22129			
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	Medic Examin	al	4a. Facility Name (if not institution, give s	treet and number)	4b. City, Town	, or Location of Death		4c. County of Death	1 5.33 A™			
-1) Examin		LOCH RAYEN I	1A CLC	Ba	ltimore	/	VA				
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bin	thday) If Under 1 Year Yrs. Months Day		8. Date of Birth Month, Day, Year	9. Birt Co.	hplace (State or Foreign untry)			
	րժ how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits			
	Marylar 8a-f s tified	Director	MD NA	Batti	more				1 Yes 2 □ No			
	th the 3a or 2 t be no		10e. Street and Number		10f. Zip Cod	e 10	1 .	Citizen of What Co	untry?			
	eath wi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13, Was Decedent o	f Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	rican Indian,			
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes Yes No If Yes, Give	If Yes, specify Cu	uban, Mexican, Puerto , No S <i>pecify:</i>	Hican, etc.)	Black, White Specify:	a, etc. ACK			
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21215-0036	l within 72 /giene. ner than " t, the Mec	Completed	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give kind of work dor life, DO NOT use retire	ed)	In F	actory				
d 2	filed wi al Hygie d other event, t	Be	17. Father's Name (First, Middle, Last)		MOTO	18. Mother's Nam	ne (First, Middle, Maide	in Surname)				
Maryland	should be file and Mental I s marked c raumatic eve	្ន	Charles NI. Per	~Kins		Helen	Cunni	ngham	0.71			
Ma	and 2 sho Health and tem 27 i s i		19a. Informant's Name/Relationship (Type)	pe, Printy	b. Mailing Address (Stre	- /	St. Balto.		1202			
Baltimore,	je 1 an t of He If item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 1	Removal from State cemete	of Disposition (Name of ery, crematory or other p	place)	Date 20c.	Location - City or Owing Mi	Town, State 111s, Md.			
ıltim	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Line fe		SON TOYEST	V.A.H-II	-11 (c)	kr Ison	21229			
B	permi Depar Impo any ir	17	Smt / Wan		Garypir	narch F/H	270 Fredh	ilton Pass	Balto mo			
			23a. Part 1. Enter the disease, or compl shock of heart failure. List only on Immediate Cause (Final	ications that caused the death. Do le cause on each line.	not enter the mode of d	ying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death			
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	e executed sian and urial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	of):							
760	cate by physic sthe b	ledic		d								
Box 68760	h certifi tending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat				23d, Date of del				
Bo	The law requires that the death certificate be are has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medical	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)			Month	Day Year			
P.0	that the	by Pt	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause	given in Part I.			the cause of death?			
rds,	equires ieen sig nould b	eted					-		robably 4 Unknown			
eco	sician: The law r s certificate has b lirector, page 2 sl	Completed					24a. Was an autopsy performed	prior to death?	completion of cause of			
al F	ian: Tr ertificat ctor, pa	Be C	25. Was case referred to medical examiner?			. Place of Death (Chec	1 Yes 2 🔀	NO TE TES	Z I NO			
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o uo	ath. r: After re fune	icate	1 Natural 5 Pending 2 Accident Investigation		injury w	ork?	200. Describe now inj	ary occurred				
Division of Vital Records, P.O.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, offic	ce	28f. Location (Street a City or Town, Sta		ral Route Number,			
Ω	ospital hours uneral ed filled	Medical		cian: To the best of my knowledge, eer: On the basis of examination and/								
	the Hithin 24 the Formplets	We		Practioner: To the best of my know	vledge, death occurred a		ce, and due to the caus		stated.			
	F ≥ F ŏ		1	M.D	DS	6508		July	12, 2011			
	241		30. Name and address of person who co		(Type, Print)	ANGRON		100	1218			
	Sta	te	3900 LOCH 31. Date filed (Month, Day, Year)	32. Fugurar's Signature	LVD 1	5HC 1/MO	KE. A	110 2	1610			
	Registra		1111 1 2 20	11 1 1	Be VI							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dây, Jüly 20°11 4:00 A M Frank Pruzenski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** ocial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 1 🛛 M 2 🗆 F Feb 12, Year) 938 **Director** Illinois <u>414-64-1254</u> 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified or once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2X No Laurel Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 9106 Lilac Park Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1956–1960 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Przywoazna Frank Pruszynski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9106 Lilac Park Dr. Laurel, MD 20723 Donna Pruzenski / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Flinal Journey Crematory 7/13/2011 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ NON SMALL CELL disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to for sells consequence of: cause. Enter Underlying Exami **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attencompleted filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PHLMONARY HYPERTENSION performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2**X** No Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month. Day, Year D64395 JULY 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 6336 CEDAR LANE COLUMBIA, MS Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1657 TILL Charles S. Poole, 201 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICIMIGO 8. Date of Birth
(Month, Day, Year
April 26, If Under 24 Hrs Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 1**X**XM 2 □ F Months Davs Hours Min 65 1946 MD Director 215-44-1977 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at with the Maryland Director r 28a-f sl notified 1 ☐ Yes 2X No Finksburg Carrol1 MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò must be i 21048 Funeral 2060 Bollinger Mill Rd. United States tems 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status "natural", or iter Armed Forces? Black, White, etc 1 Never Married 2 X Married Ď Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) Sam's Deer Processing Butcher/Meat Cutter is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ß Mary Virgie Duvall Maurice T. Poole Page 1 and 2 should ment of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2060\ Bollinger\ Mill\ Rd.\ Finksburg,\ MD\ 21048$ 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains Brenda Poole (wife) Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Removal from State 4 Donation 5 Dother (Specify) Evergreen Mem Gardens 7/15/2011 Finksburg, MD 22. Name and Address of Facility

Burrier-Queen Funeral Home and Crematory Old Liberty Rd. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each. 21GHT VENTRICLE Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ARTERY burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate has performed? 1 Yes 2 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗹 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After iniury 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, by 4 Homicide determined City or Town, State filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. претер (Check only one) of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 7/9/11

Registrar

DHMH 17 Rev 7/2009

State

SAlisbun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll St.

32. Registrar's Sign

100E.

Webberg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Medical 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** If Unde Country) Maryland Months Days Hours Min 0272871930 81 216 24 0692 Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Glen Burnie Anne Arundel Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 21061 403 W. Ordnance Road Apt. 101 ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Specify: 3 Divorced 4 Divorced Year or Dates. other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Baltimore City Policeman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Pinkine Marjorie Bramble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 W. Ordnance Rd. Apt. 101 Glen Burnie, MD. 21061 Evelyn Pinkine / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 07/11/2011 Glen Haven Mem. Park Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Fu eral Service Licens 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ (upziL Medical Examiner resulting in death) Due to (or as a consequence of): DOU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 **N**0 1 National 2 ER/Outpatient 3 DOA

28a. Pate of injury
(Month, Day, Year)

28b. Time of injury
injury

28c. injury 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ye ar **Physician** PODBERESKY 3:46 PM NOAH JUL 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner N/A MOSPITAL BALTIMORE SINAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/12/1915 Birthplace (State or Foreign Country) POLAND 5. Social Security Number (In yrs. last birthday) 95 Yrs. **Funeral** Months Days 1 X M 2 □ F 212-30-2072 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show ns 23a or 28a-f shov BALTIMORE BALTIMORE MD 1 ☐ Yes 2X No Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with USA 7202 ROCKLAND HILLS DRIVE #501 21209 Funeral death v permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Eventual once. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐Yes 2X No Specify <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ GROCERY STORE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NAOMI BERKMAN **PODBERESKY** YACOV ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7202 ROCKLAND HILLS DRIVE #501, BALTIMORE, MD 21209 19a. Informant's Name/Relationship (Type. Print) MINA PODBERESKY/WIFE 20b. Place of Disposition (Name of BOBROISKER BENEFICAL 07/10/2011 CIRCLE LODGE 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., TNC 21. Signature of Funeral Service Live 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ANO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 14 Natural 5 ☐ Pending investigation n 24 hours after death.
e Funeral Director: Afteletely filled in by the fur 1 ☐Yes 2 ☐No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's agnatur Year State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 311m=58am Physician/ July Kathryn Piddington 10^{ay} 20111 9:00 AM K. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Brightview Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 1929 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Hours 12/9/2011 Maryland 215-26-8544 **Director** 81 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is anawfed other than "natural", or items 23a or 28a-f sho miportant: If item 27 is anawfed other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2138 Sherwood Lane 21078 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2X No Specify 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Willard Herma Reeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2925 Haddington Court, Abingdon, MD 21009 Thomas Piddington / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Harford Mem. Gdns. 7/15/2011 Aberdeen 4 Donation 5 Other (Specify) Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 Signatura Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dements e sina en disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed this certificate Yes 2 XNo 1 🗌 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral of the funeral completed filled in by the funeral completed filled in the funeral completed filled 1X Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

DAVID 5 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

03227-

29d. Date signed (Month, Day, Year)

July 11; 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day 2011 ear Physician/ Barbara Smith Requa 10, 8:30 A M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death Bel Air County of Death Harford 308 Plantation Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours 1 🗆 M 2 🔀 F 86 575-20-5463 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Harford Bel Air MD 1 XYes 2 ☐ No 10f. Zip Code 21 01 4 10e. Street and Number ō 10g. Citizen of What Country? 308 Plantation Lane Funeral items 23a USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Customer Transportation Service traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary McKain Smith ပ္ Robert permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Sunset Drive, Bel Air, MD 21014 Robert Requa / Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 7/12/2011 Woodbine, MD Final Journey Crem. 22. Name and Address of Facility
Maryland Cremation Services
PO box 1413, Baltimore, MD Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ YMPHOMA disease or condition MONTH-Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or impury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) been signed by the atte in the past 12 month Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other Certificate: To 1 Inpatient 2 ER/Outpatient 3 DQA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

108m

and address of person who

State

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes On the Copies Are Legible.											
				_ State		•		Mental Hygi	ene ₂ 011	22136		
				Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	of Death	2. Date of Death	eg. No.	3. Time of Death		
		Physicia Medi		Doris A. Ross					9 ^{Day} 20 191	11:30 A M		
(Exami			reet	Ba	n, or Location of Deat		4c. County of Dea	th		
		Funeral Director		316-30-2548 10M2VF	7. Age (In yrs. last birth	Months Da	ear If Under 24 Hrs ays Hours Min		9. Bir	thplace (State or Foreign puntry)		
		ryland t-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	1				10d. Inside City Limits 1 ■ Yes 2 □ No		
4		with the Maryl 23a or 28a-f st be notified	Funeral Director	10e, Street and Number		10f. Zip Coo	de	10	Og. Citizen of What Co			
0		death wi	-unel	11. Marital Status 12. Was Deced	lent Ever in U.S.	13. Was Decedent	of Hispanic Origin? (S Duban, Mexican, Puer	pecify Yes or No-	14. Race - Ame	erican Indian,		
1.3	215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes I Yes, Give Year or Dat	2 No	1 Yes, specify C		to Rican, etc.)	Black, Whit	e, etc.		
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0				Denise lay or (Dan	ahter 2	Mailing Address (Str	reet and Number or Ru	Balt	City or Town, State, Zi	D 2126		
1	Baltimore,	Φ ° = =		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 5	20b. Place of cemetery	y, crematory drother	place)	7	0c. Location - City or	Town, State		
	altin	permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Lisen ee	New	22 Nava	hersof all ty Co	reene fu	real E	enices		
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5		Physician		shock, or heart failure. List only one cause on eac Immediate Cause (Final disease or condition	als trai	Lu	us Co	m cor	-	Interval Between Oliset and Death		
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217	0	be executed sician and burial-transit	l= 1	that initiated events resulting in death) Last C. Due to (o	r as a consequence of	n):						
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	3eco	sician: The law r certificate has b lirector, page 2 s	Completed					24a. Was an autopsy perform	ed2 prior to death?	topsy findings available completion of cause of		
	tal	nding Physician: 7 th. : After this certifica : funeral director, p	Be C	25. Was case referred to medical examiner?		26	6. Place of Death (Che		No 1 L Yes	5 2 🗆 110		
	ŤVi	Physic this c	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In 27. May 1 of Death 28a. Date o	npatient 2 ER/Outp	patient 3 L DOA	Other: 4 D Nursing I		ce 6 Other (Spec	cify)		
	o uo	death.	ficate	1 Natural 5 Pending (Month 2 Accident Investigation		jury v	njury at vork? I □ Yes 2 □ No	28d. Describe how	/ Injury occurred			
			al Certificate:		f Injury - At home, farn g, etc. <i>(Specify)</i>	m, street, factory, offi	ce	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,		
		e Hospital or n 24 hours afte e Funeral Dir bleted filled in	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis only only) 3 Certifying Nurse Practioner: To	of examination and/or	investigation, in my o	pinion, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.		
4		To the within 2 To the comple	2	29b. Signature and title of certifier	dila (1 Cc)		ense number		d. Date signed (Monti			
		16 de		30. Name and address of person who completed cause	of death (Item 23a) (Ty	ype, Print)	10.11	1 01	1 / 1/	1/228		
		Sta	te	31. Date filed (Month Day Jear) 32. Re	gispar's Signature	5/60	V. KILL	my to	Bul	4 list		
		Registra		JUL 1 2011 Kenur	o. par			V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 3:48 A Thelma Cudahy Ritter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Harmony Hall Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 24, 1 □ M 2 🕱 F Months Davs Hours Min Year) 907 Iowa Director 098-03-6976 103 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland notified at 10c. City, Town or Location Director 1 ☐ Yes 2X No Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò traumatic event, the Medical Examiner must be 23a Funeral United States 5049 Ten Mills Road 21044 items 2 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 0 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: and Mental Hygiene. is marked other than "natural", Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be i ment of Health and Menta Lulu Kloss John Cudahy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 5049 Ten Mills Rd. Columbia, MD 21044 John C. Ritter / Son other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) 7/13/2011 Woodbine, Maryland Final Journey Crematory 21. Sign are of Funeral Service L. nsee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a: Part 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter chaerlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subsete \text{ No} \) for 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 4 ☐ Pregname g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 🗆 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: 7) the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 [29b. Signature and title of cer 29c. License numbe 11,2011 8m

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of p

31. Date filed (Month, Day,

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any

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ RAMSEY-LANSEY 2011 ATANYA Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Howard Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Hours June 15, Year) 1957 213-70-0822 1 M 2 Maryland 54 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Doş artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a State 10c. City, Town or Location 10d Inside City Limits Director 1 🗆 Yes 2 😿 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21045 9459 Two Hills Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: **Black** 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Daycare Licensing Specialist State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Christine Branch Alonzo Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven J. Lansey (husband) 9459 Two Hills Court Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Balto/Wash. Crematory 7-10-2011 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility
5555 Twin Knolls Road Funeral Homes, Inc. Columbia, MD 21045 23a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ RESPIRATORY disease or condition Medical resulting in death) Examiner TASTATIC Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical YTRAVASCULAR Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Vear Pregnant at time of death Yes 2 No 1 Yes 2 Unknown the should be detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 1 Tes Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ည 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this . Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier NAN DA, MI CHARU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANE, COLUMBIA CEDAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10^{Day} Physician/ $\overset{\text{Month}}{\operatorname{Julv}}$ 201^{Year} 2:30 P.M Wilmer A. Rehmeyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chapel Hill Nursing Home Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F 96 Yrs. Months Hours Min Nov. Pear 1914 214-01-0630 **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 United States 3603 Milford Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black White etc. ģ 1 Never Married 2 K Married Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Clock, Watch, Jewelry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Repair Shop Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Florine Belle Young Wilmer Louis Rehmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3603 Milford Mill Road Baltimore, MD Vanna Rehmeyer Wife 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory July 12, 2011 Winfield, MD 21. Signature of Funeral Service Lices 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ schemic y ears disease or condition , Medical resulting in death) **Examiner** ones Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a conseque and Due to (or as a consequence of). resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ٩ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 ANatural work? 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifie 737513 12, 2011 pleted cause of death (Item 23a) (Type, Print) 2835 **21200**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris G. Riley July 8, 26^y11 2:32 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Year 1922 1 🗆 M 2 🖾 F Months Days Hours Min. March 21 Georgia 89 254-24-2515 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10825 Fox Hunt Lane 20854 United States death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Orvill Greeson Nell Baker and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 10825 Fox Hunt Lane, Potomac, Maryland C. Frank Riley, Jr./Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory of other place)
St. Gabriel's
Cemetery July 12, 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Potomac, Maryland 4 Donation 5 Other (Specify) 2011 ur val Se ce Licensee Bethesda-Chevy 21. Signature Robert A. Pumphrey Funeral Home Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ Minutes resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, it is a cause. Enter Underlying Due to or as a consequence of Examir and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical that the death certificate be 1, Doris 07/08/11 02324M Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed Were autopsy findings available prior to completion of cause of autopsy performed death? certificate Yes 2 N 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 2 1 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the I within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) 054336 7/8/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonard Matthew, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, D 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ROBINSON Physician/ EVELNE Tarty 20 ear 9,301 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 278 PHEBUS AVE FREDBRICK FREDE RICK Social Security If Under 1 Year If Under 24 Hrs. Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country) MD Days Min. Month, Day, 63 212-54-3250 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must be actived any 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director FREDERICR MD FREDERICK Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PHEBUS Funeral AVE USA 21701 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BIACK 3 Divorced Year or Dates 16a. Decedent's Usual Occupation unit 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 W. South St; Frederick, MD 21701 Gary Rollins - Funeral Dir 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in State cemetery, crematory or other place, 22. Name and Address of Facility GARY L. ROLUNS 21. Signature of Funeral Service Licenses Collin WEST SOUTH ST FREDERICK MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ ALCOHOLIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and end filled in by the funeral director, page 2 should be detached for use as the burial-transit lead filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by #20 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2**X** No Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) 10062222

State Registrar 31. Date filed (Month, Day, Year) - -

FREDENCE.

ess of person who completed cause of death (Item 23a) (Type, Print)

)UITE#135

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

		- For State Registrar		Ce	rtificate	of D	eath			Re	g. No.		
Physician Medical Examine	/ er	1. Decedent's Name (First, Midd Solomon Rees	e,Jr.						۸ ا	Date of Death Month une 27, 2	n Day Year		3. Time of Death 2217 hrs
_		4a. Facility Name (if not instituti Prince George's Hos	· -	iumber)			City, Town, o	r Location o			4c. County of Prince G	eorge	
Funeral Director		5. Social Security Number 416-50-7529	6. Sex	7. Age (In yrs. I	ast birthday	_	f Under 1 Year Months Day		1		16,1940	Foreign	
and fabow any nice.		Usual Residence of Decedent P4 §セセ デic t off ^{b. County Columbia}	,		Town or L								10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		10e. Street and Number 2300 Good Hop	e Road			10	of. Zip Code 20020			10	g. Citizen of Wha	at Coun	try?
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once red by Funeral Director	Lanera	11. Marital Status 1 Never Married 2 X N	Armed I	2 No		If Yes, s	ecedent of Hi specify Cuba	n, Mexican,			14. Race - White, Specify:	etc.	an Indian, Black,
hours after and an arteral and arteral	200	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Dece	edent's L	s 2 X No Isual Occupa of working life	tion (Give k		done	16b. Kind of Bus		
11215-0036 Id be filed within 72 hours aft fental Hygiene. narked other than "natural" event, the Medical Examine event, the Medical Examine or Be Completed by		12 17. Father's Name (First, Middle		(1-4 or 5+)	Mi]	lita	ry	18 Mothor	e Namo (Eiro	et Middle M	U.S.Go	ver	nment
De fill	3	Solomon Rees Iga. Informant's Name/Relations	e,Sr.		Tab Me	niling Ad	droos (Sta	Glad	ys Mat	tthew		01-1-	7.0.11
_ 급 등 등 등	Ĺ	Kenn th Reese,			312	1st	Place,	Pleas	ant G	rove /	oer, City or Town \labama 20c. Location - G	35	127
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic.		1 Burial 2 Crematio	Specify:	rom State	crematory o abama	Nat:	ional		7-7-	-11	Monteva:	llo,	Alabama
		21. Signature of Funeral Service Michael F. Mu	argullo	agus ad the death	Ø	5009	Harfo	rd Ro	ad,Bal	Ltimor	uneral (e,Maryla	and	21214
Physician /Madical Examiner	-											Approximate Interval Between Onset and Death	
<u>.</u>		Sequentially list conditions, fany, leading to immediate	b	a consequence o									
red Insit		cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	6	a consequence o								250	<u> </u>
760, ficate be executed g physician and the burial - transit		UNPENDED	d AMENDED					_					
ox 68 ath certii attending or use as		F FEMALE: 3b. Was decedent pregnant in the past 12 months?	he 1 Live	nant at time of de	2	Fetal de	eath 3 (Specify)	Ectopic	pregnancy		23d. Date of d Month	elivery Da	ay Year
ries that the de signed by the lee detached for detached		Part II. Other significant condit	9 Onki		esulting in t	he under	lying cause (given in Par	t I.				ne cause of death?
Records, The law requires firate has been signage 2 should be Completed										24a. Was ar autopsy	24b. We	ere auto	opsy findings available mpletion of cause of
of Vital Recing Physician: The land After this certificate huneral director, page 7		5. Was case referred to medica					26.Place	of Death (Check only	perform Yes 2		ath? ✔ Yes	2 No
F Vital Physician This cert al directo	L	examiner? 1 Yes 2 No		Inpatient 2								Other:	
Division of Vital Records, tal or Attending Physician: The law requirers after death. at Director: After this certificate has been sited in by the funeral director, page 2 should be rification: To Be Completed		7. Manner of Death 1 Natural 5 Pend 2 Accident Inve	stigation Jun 27,	Day,Year) : 2011	28b. Time FOUND: 2131 hrs		1 ,	ry at Work? Yes 2 ✔ I	_{No} Sub	ject shot	w injury occurred	i 	
Division or apital or Attending tours after death. The filled in by the fune. Certification:		4 V Homicide dete	id not be	multi-Famil		street, fa	ctory, office b	puilding, etc.		or Town, Sta			al Route Number, City oton, DC
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification		Medical Exa	hysician: To the be aminer:On the basis and manner:	of examination ar									
	2	9b. Signature and title of certifie	er				29c. Licens O.C.I				29d. Date signed June 28, 20		h, Day, Year)
/	3	Name and address of person Ana Rubio MD. Ass	who completed cau sistant Medical			altimo	re Street,	Baltimore	e, MD 21	223			
State Registra	4	1. Date filed (Month, Day, Year)		egistrar's Signatu	par	Kal							

State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Schlack July Physician/ Mary Frances 12 5:34 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Oak Crest Retirement Communit Baltimore 7. Age (In yrs, last birthday) 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** 217-16-4162 1 M 2 XF Months Days Hours Min Month, Day, Year) 0/23/1922 Country) 88 Director MD Usual Residence of Decedent Schlack, Mary 7/13/11 534m 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore MD1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral Walther Blvd 21234 8832 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mexiconce. Elementary/Seconday (0-12) 12 Union Worker Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 John Loeffler Clara Groslop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2315 Maryland Ave., Baltimore, MD 21218 Mary K. Northrup/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Final Journey Crem. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 7/14/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO box 1413, Baltimore, MD Dorota Marshall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementis disease or condition End Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the burial attending physician Physician/Medical certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Į, Day Month Pregnant at time of death 5 Other (specify) detached t the To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should t 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify, 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 2011

49

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Street	-	5	1	Sec.	-		

		1- For State Registrar		Certificat	e of Death		Reg.	∠ ∪ ≀ No.	1 2214
Physicia Medical Exami		1. Decedent's Name (First, Middle,La Gerry Ashtor	,	.] 7		l N	ate of Death	ay Year	3. Time of Death 1705 hrs
Wedicai Examiner		4a. Facility Name (if not institution, gi		riand	4b. City, Town, or Location		uly 6, 2011	4c. County of De	
		6100 Everall Ave Apt. 415 Baltimore							
Funeral Director		5. Social Security Number 6. S		(In yrs. last birthd	y) If Under 1 Year If Und Months Days Hour			TEO	Birthplace (State or reign
Director			€ M 2□F 6	59yrs.	Yrs. Working Days Flour	S (VIII).	11.13.	,1941	Country) MD
my		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or	Location				10d. Inside City Limits
and show a	Ē	MD		Baltim	ore				1 Yes 2 No
faryla 28a-f.1 1 at on	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
215-0036 be filed within 72 hours after death with the Maryland nial Hyggene. rked other than "natural", or items 23a or 28a-f sho cut, the Medical Examiner must be notified at once.		6100 Everall A	venue Apt	415	21206		υ	ı.S.A.	
th with terms 2 at be u		11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ex Armed Forces?	ver in U.S. 1	 Was Decedent of Hispenic Ori If Yes, specify Cuban, Mexican 			14. Race - An White, etc	nerican Indian, Black,
ter dea		Wildowed 4 Divorced II Yes Give Year							White
ours af ntural camin	d by	15. Decedent's Education (Specify of	or Dates	leted) 16a. De	cedent's Usual Occupation (Give	kind of work	done 1	6b. Kind of Busine	ss/Industry
6 n 72 h ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	•)	ing most of working life. DO NOT RWYET	T use retired)		0+-+	
5-003 iled withii Hygiene. d other th	E	17. Fether's Name (First, Middle, Las	4			de Nama (Fire	et Middle Ma	State I	rarm
11215-0036 Id be filed within 72 hours at denial Hygiene. narked other than "natural event, the Medical Examin	To Be	George Ashton	•	ınd			a Albe		
7. 2 9 3 5		19a. Informant's Name/Relationship (Type, Print)	19b. N	failing Address (Street and Nu				ate, Zip Code)
		Wayne Sutherl 20a. Method of Disposition	and/broth		Krisswood Ct.	. Nott	ingha	m, MD 2	21236
Baltimore, Mormit. Pages I and 2 Department of Health Important: If item 2 injury or other traue		1 Burial 2 Cremation 3	Removal from State	crematory	isposition (Name of cemetery, or other place) Deake Cre.	Da	I -	Oc. Location - City	
Baltimo permit. Page Department of Important: injury or otd		4 Donation 5 Other Specify 21. Signature of Funeral Service Lice							lle, MD
Ba perm Depa Inpr	Į	Z Q X Q	Ali	1443	22. Name and Address of Facili	"CAFA- asture	-Steph es Dr.	en D. I Balto	Cohrmann, PA , MD 21286
Physician		23a. Part). Enter the disease, or com	plications that caused th	ne death. Do not e	nter the mode of dying, such es	cardiac or res	piratory arrest	, shock, or heart	Approximate Interval
/Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease a, Intracerebral Hemorrhage Between Onset and Death							
	je j	or condition resulting in death)	Due to (or es a consequente de la consequencia de l		Disease				
		Sequentially list conditions, if any leading to immediate b. Hypertensive Cardiovascular Disease Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. events resulting in death) Last Due to (or as a consequence of):							
cuted ind transit	Ä	d							
760, icate be executed physician and the burial - transit	Medica	UNPENDED	AMENDED						
8760, ificate be	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy	Fetal death 3 Ectop	ic pregnancy		23d. Date of deliver Month	very Dey Y ear
Box 68	Physician	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at tin		Other (Specify)				
hed the	Phy	Part II. Other significant conditions	9 OHAROWII	out not resulting in	the underlying cause given in D	ent I	23e Did toba	cco use contribute	to the cause of death?
P.C es that igned 1	á							es 2 No 3 Probably 4 Vunknown	
of Vital Records, P.O. or Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detact	Completed						24a. Was an		autopsy findings evaileble
eco he law ate has	E C					_	autopsy performe 1 Yes 2	ed? death	
Vital Re(ysician: The his certificate director, page	Be C	25. Was case referred to medical			26.Place of Death		one)		
of Vit ing Physici After this uneral dire		1 Yes 2 No	Hospital: 1 Inpatient					sidence 6 🗹 Ot	her: Scene
C # _ ^ 4		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year	28b. Tim	e of Injury 28c. Injury at World	_	. Describe hov	v injury occurred	
Division tal or Attendi rs after death a Director: A	icat	2 Accident Investigat	28e Place of Injur	rv - At home, farm	street, factory, office building, e		Location (Stre	eet and Number or	Rural Route Number, City
Division pital or Attencours after death feral Director: filled in by the	Certification:	3 Suicide 6 Could not determine	De				or Town, Stat		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physic one) Certifying Physic	lan: To the best of my k	knowledge, death	occurred at the time, date end pl	lace, end due	to the cause(s	s) and manner as s	tated.
To th withir To th comp	Medical	29b. Signature and title of certifier	and manner stated.	nation and/of inve	stigation, in my opinion, death or				
		Charles and the or certifier	200		O.C.M.E.		- 1	9d. Date signed <i>(i</i> July 7, 2011	wontn, Day, Year)
Som	}	30. Name end address of person who	completed cause of dea	ath (Item 23a)		···.		., .,	
		Carol Allan, MD Assista		, ,	Baltimore Street, Baltim	ore, MD 2	1223		
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,				
Regist	TGIL	JUL 1 ~ ZUII /	more p.	17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Month Physician /Medical Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** N/A 9. Birthplac Country) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 1 □ M 2X F Yrs. Director 212-36-6690 73 9/15/1937 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Director Baltimore MD N/A10e. Street and Number 10f Zip-Code 10g. Citizen of What Country? 21206 4348 Roberton Ave. IISA Funeral Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2X Married 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Black à Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker ResersCompany N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Francis Edwards Henderson Scott မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4348 Roberton Ave Baltimore, MD 21206 et of Disposition (Name of Date Date 20c. Location - City or Town, State Fred L. Bland- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/13/2011 OwingsMills, MD Garrison Forest 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H 1101 E. North Wholes (Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a each list. Approximate Interval Between Onset and Dea Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of, The law requires that the death certificate be executed and burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 | Fetal death 3 Tectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No the a 9 Unknown 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 □ No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner? Other: 4 \sum Nursing Home 2) No 1 Tes 2 ER/Outpatient 3 DOA npatient 5 Residence 6 Other (Specify) Certification: To Manper of eat funeral 28a 28b. Time of Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural (Month, Day Year Injury ∠ ☐ Accident3 ☐ Suicide 1 Tes 2 🗌 No filled in by the after death Could not be 28e. Place of injury - At hon building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) udhari SW $\mathcal{N} \mathcal{D}$

1 0

Registrar

State

31. Date filed (Month, Day, Year)

12

DHMH 17 Rev 1/2001

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Dav **Physician** 2011 5 -helmini /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** N/AThe Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 X F 68 10-30-1942 MD 220-38-8888 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 □ No Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21218 3823 Crestlyn Road Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify. Maryland 21215-0036 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) John Hopkins Hosp. Clinical Asst. 12th N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geneva O. Turner Daniel Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 2663 Oswego Ave. Baltimore, MD 21215 Delores Campbell- Aunt Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/14/2011 Baltimore, MD Loudon Park Cemt. 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 permit. 21. Signature of Faneral Service Licensee Brank Melle Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-transi and Due to (or as a consequence of): physician Box 68760. Physician/Medical the as attending use a 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Year Live birth Month Pregnant at time of death 5 Other (specify) signed by the att 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Division of Vital Records, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 No Yes 1 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 2 No Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes ٩ this 28d. Describe how injury occurred funeral 28a. Date of Injury 28h Time of 28c. Injury at Work? 27. Manner of De ith Certification: (Month, Day Year) after death. Director: After t 1 Natural 2 Accident 5 Pending investigation or Attending 1 Tes 2 No the 1 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide filled in by 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the Hospital 29a. Certifier Medical (check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert PES-000

Registrar

State

Margaret

31. Date filed (Month,

Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hayes

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUTY 7 2011 8:45 Spittle , Sr. Donald Franklin Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Bel Air Health and Rehab 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months PA PA July 26, 1918 **Director** 204-03-3401 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hijury or other traumatic event, the Medical Examiner must be notified any once. 10a. State Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Baltimore Dunda1k 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7795 Peninsula Expressway #203 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ₺ Widowed 4 □ Divorced Specify. Year or Dates. WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Machinist Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Elmer Spittle Sarah Anne Travitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Boxelder Drive Edgewood, MD 21040 612 Boxelder Drive Michele L. Vasta (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/9/2011 Towson, Maryland 4 Other (Specify) Signature f Funeral Service License ²²Duda Ruck Fulleral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the deat. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ·20m Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: USe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atte in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed tor: After this certificate has been sive the funeral director, page 2 should in 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide after death. 1 🗌 Yes 2 🗆 No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Esertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D56545 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHILPI KHUSUA 615 W. MACHAIL JR. # 102, BELAIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Geraldine H. Stafford 20 m 11:55 AM Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Middle River 4c. County of Death Examiner Ivy Hall Nursing Center Baltimore 5. Social Security Number 212-12-6500 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 13 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗆 🗶 Hours Min. Country 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Baltimore Essex MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 718 Riverside Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: White 3 XWidowed 4 Divorced Specify. Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame)
EMILY NOTTMAN Walter M. Hart ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Riverside Drive Baltimore MD 21221 Lee Strohkorb /god-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7/15/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Home of Essex 2122 Connelly Funeral 23a. Part 1. Enter the disease, or complications that caused the death.) o not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 9 disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as attending IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. المادية بالمادية المادية الما Part II. **Other significant conditions** contributing to deat**** but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 000 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nin 24 hours after death.

the Funeral Director: After this on a pleted filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 \square Pending 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple only one) title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASTERN OV 12 ASERM 709. 31. Date filed (Month, Day, Year) State

Registrar

1 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 8:45 A M Joseph Michael Sowinski, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery National Lutheran Home Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral**)^{Year)} 1940 Months 1 X M 2 - F Hours Sept 29 Pennsylvania Director 147-30-0143 70 Usual Residence of Decedent If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 15311 Pine Orchard Drive #1K 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever III 0.3. Armed Forces? 1 \boxtimes Yes 2 \square No If Yes, Give Year or Dates 1963–1969 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Cabinet Maker Manufacturing alth and Mental Hygie 27 is marked other r traumatic event, ti Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked Josephus Sowinski Regina Cichocka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl A. Hutchens / Wife 15311 Pine Orchard Dr. #1K Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/14/2011 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 nverle MO1251 23a. Part 1. Enter the die ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart is ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Enel Pacs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Cerebrovaseular 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 2 😝 No of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending Division Accident
Suicide 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🗌 No Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier @ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 To the I within 2 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 005061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (*Month, Day, Year*) **JUL 1 2 2011**

DHMH 17 Rev 7/2009

MARYLAND

Rockulle

32. Registrar's Signature

SAMUEL G-MANGRAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5416 **Physician** BERI 4b. City, Town, or Location of Death /Medical 4a. Facility Name (If not institution, give street and number) Examiner N/A **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number June 30,1934 Baltimore, MD. **Funeral** 77 213-30-5971 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No death with the Maryland 10a, State 28a-f show Examiner must be notified at Cockeysville Maryland Baltimore County Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 23a or 21030-3205 104 Pine Bark Court 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 № Yes 2 □ No If Yes, Give Year or Dates: or items 11 Marital Status ould be filed within 72 hours after of Mental Hygiene. White 1 Never Married 2 Married Specify 1 Yes 2 No Specify: ģ 3 Widowed 4 Vivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry "natural", Completed 15. Decedent's Education Baltimore the Medical (Specify only highest grade completed) Gas & Electric Elementary/Secondary (0-12) College (1-4 or 5+) Industrial Lighting Engineer other than 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norva Latham George Showers Stocksdale and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wilmington, DE. 19808-4412 411 Woodstock Lane Mrs. Heidi Sharpe (Daughter) item 27 20c. Location - City or Town, State
(Baltimore County) 20b. Place of Disposition (Name of Baltimore, 20a. Method of Disposition Pages 1 Wednesday Dularey Valley Mellocial
Gardens Department of H
Important: If ite
any injury or of 1 Surial 2 Cremation 3 Removal from State Timonium, Maryland July 13,2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Left by L. Garr, Sr. O. S. 2 Name and Alternatives Fureral and Cremation Center, P.A. 21093-2215 Lic.#M00677 Timonium, Marcyland 2325 York Road Approximate Interval Between Onset and Death re. If complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. P 1. or the iseas shock, or heart failure. isease Sepsis Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Pseudomonas Univary tract infection Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of) and resulting in death) Last physician Box 68760, Physician/Medical death certificate be use as the 23d. Date of delivery attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death Day 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) should be detached 9 Unknown P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 3 Probably 4 Unknown 2 No þ 1 TYes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 🗌 Yes 2 No 1 TYes certificate 26. Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 3 DOA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient ٩ 28d. Describe how injury occurred 28c. Injury at Work? this 28a. Date of Injury (Month, Day Year, 28b. Time of 27. Manner of Death Certification: Injury 5 Pending investigation 1 Natural 1 TYes М 2 Accident 28f. Location (Street and Number or Rural Route Number, eral Director: A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide City or Town, State) 4 🗌 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 hours a Hospital 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number July 8 2011 D6463. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Wesley Smith Month Day Year 5147 PM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 53 Yrs. 8. Date of Birth
(Month, Day, Year)
07-12-1957 Funeral 6. Sex Birthplace (State or Foreign Country) Months Hours 216-66-4358 1 ▼M 2 □ F Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Catonsville 1 Tes 2 No 10e. Street and Number 10f, Zip Code 10g Citizen of What Country? items 23a Funeral 14 Dunbar Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Maryland 21216-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or I any injury or other traumatic event, the Medical Examin Completed by 1 M Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2X No Specify: Black Specify: 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Landscaping 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert L. Smith should be Olive Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14 Dunbar Ave. Balto. MD 21228 Sister Rose Bacon Page 1 and 2 Báltimore, 20a Method of Disposition 20b. Place of Disposition (Name of Date Ardent Crem. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-09-2011 Hanover, MD Signature of Funeral Service 22. Name and Address of Facility Phillip A Weatherford FS PA 2431 E Oliver St Balto Md 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atelectasis Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): Abuse death certificate be executed Alcohol burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No detached Hospital or Attending Physician; The law requires that the Records, P.O. completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M. D P. 24064 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Balti more 900 Caton MD-21229 31. Date filed (Month, Day, Year) Registrar's Signati State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G91//14/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Z. Seldon July 2011 5:20 A M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Baltimore Catonsville 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Months June, Day, 1 ★ M 2 □ F Hours Year 928 112-20-0892 83 Yrs. Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane, CC313 21228 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: nem 27 is marked other than "natural", other traumatic event, the Medical Exal Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineer 4 Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental I is marked on ၉ Mark R. Seldon Altshiller Annette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Denise Seldon / Daughter 9178 South Cedar Hill Way, Lone Tree, CO 80124 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/08/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor ale 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ranal tailure Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami cardiomyopath and -trans schemic that initiated events resulting in death) Last burial-t ng physician as the burial Physician/Medical Records, P.O. Box 6876 Hospital or Attending Physician; The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform this certificate Yes 2 X N 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in an analysis of examination and/or inventioning in an analysis of examination. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person iden Choice Ln State 1 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 a 7:40 PM 10. Mildred R. Seybold Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brighton Gardens Of Columbia Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 □ M 2🗓 F Months Hours Min. 1912 Maryland 2**17-**22**-**2057 Yrs Director 98 Oct Usual Residence of Decedent e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No Elkridge Howard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5880 Bonnie View Lane 21075 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Department Store 11 permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, th. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Laura Horn Harry Stolte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bauman, Daughter 5880 Bonnie View Lane Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State 07/11/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Mmai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Months Immediate Cause (Final Physician/ Debility disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Exam Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): inding physician a use as the burial-1 Physician/Medical P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Intra abdominal Malignancy 1 Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 X No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) LIVING 1 ☐ Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? 5 Pending iniury 1 X Natural thin 24 hours after death.

the Funeral Director: At mpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MO

14

DHMH 17 Rev 7/2009

State Registrar

Harry Li, 8600 Snowden River Parkway #301 Columbia, MD 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D56531

July 11, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 29^t 2011 June 3:45 P Sullivan Lassahn Naomi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Feb 20, Year) 1 🗆 M 2 💢 F Maryland Yrs. **Director** 213-03-5865 97 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Timonium Maryland Maryland Baltimore 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21093 USA 262 East Padonia Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မှ John Calvin Lassahn Dorothea Letschin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) East Padonia Road, Timonium, Craig D. Sullivan, Sr./Son 262 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 7/1/11 Bornation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. bryan Clary Padonia Road, Timonium, MD 21093 W. Part 1 Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Souse (Final Onset and Death Ph sician/ disease or condition DERVOIDSE Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l performed Yes 2 certificate Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only on within To the 29b. Signat e and title of 29c. License number 29d. Date signed (Month, Day, Year) 200713 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signatur

St. Suite 4105, Baltimore, MD 21204

State of Maryland / Department of Health and Mental Hygiene 2 1 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day O 3 Year JUL 2140M Whitridge Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SINA DAVID MURCE HOSPITAL BANDMORE N/A 5. Social Security Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 213-34-4083 9/11/1938 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified MD N/A 1 X Yes 2 No Baltimore 10e, Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? 3915 Barrington Rd. Apt. 21207 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Force 1 Never Married 2 X Married Black, White, etc. ò 2 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) International WH Laborer 10th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph W. Thomas <u>Rose Johnson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Thomas-Daughter 1006 Druid Hill Ave. Balto., MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Trinity Cemetery Crematory or other place) 17/12/2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H MD 21202 1101 E. North Mulh Ave. Baltimore, 224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ TAGE END disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and d be detached for use as the burial-transli Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 2 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c, Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 180 022011 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address SINA HOSPITAL BALTIMORE FUTTERL DO JOHN 31. Date filed (Month, Day, Year) State 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Year olunda Taylow AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arundel Kind Annalolis Anne Madical Put-Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 - M 2 - F Months Hours 0672471976 35 Washington, Director 218-11-6156 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD PG Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8288 Quill Point Drive USA 20720 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XX Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7/6 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Executive Assistant</u> Private vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Taylor Deborah Higgins traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Floyd - Mother 8288 Quill Point Drive; Bowie, MD 20720 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory | 07/15/2011 Beltsville, Maryland 21. Signature of uneral Service Ligensee 22. Name and Address of FaciliTreeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 . Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ I/2 Medical resulting in death) tew Due to (or as a consequence of): Examiner yeus andio Myo Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): oke Cause (Disease or liniury ng physician and as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death Month Year 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably ♣☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2, No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 (No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, Year) Natural 5 Pending work? Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Ye 200 2001 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 4, Day 20<u>11</u> Physician/ Alice P. Timmins 9:00AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village 9504 Aspenwood Court Montgomery Social Security Number
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, Year

 March
 31,
 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Year) 1930 Massachusetts 028-22-8583 Director 81 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 ☐ Yes 2 K No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 9504 Aspenwood Court United States 20886 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked where 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Munitions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Aime Noe Peloquin Helen Beadreau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice L. Timmins/ Daughter 9504 Aspenwood Court, Montgomery Village, Md 20886 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium Inc. 1 Burial 2 X Cremation 3 Removal from State July 2011 4 ☐ Donation 5 ☐ Other (Specify) 9 Bethesda, Maryland 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Lic. M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of; burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be P.O. Box 68760 use as the IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year the 9 Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 X No ancer 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After injury 5 Pending work?
1 Yes 2 No Accident Investigation npleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H-Robert Derschl July 5, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Robert Birschbach,

Year) 2 2011

Registrar's Signature

cour

M.D. 201 Russell Avenue, Gaithersburg, Maryland 20877-2800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 James E. Thigpen ŏ4 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours 08/08/1932 Director 241-40-3754 North Carolina Usual Residence of Decedent or 28a-f show notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits Director Prince George's Landover 1 XYes 2 No P 10e. Street and Number 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral 3 Norair Avenue 20785 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Force 0 Black, White, etc. 1 Never Married 2X Married ☐ Yes 2X No 2 Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file of Mental I marked o ပ Arthur Thigpen traumatic Rosa Lee I and 2 should by I Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie Thigpen/Wife 3 Norair Avenue Landover, MD 20785 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit, Page 1 and Department of Hamportant: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 07/09/2011 Suitland, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequente **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to par as a consequence of attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Year signed by the g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) **Anpatient** Certificate: 27. Manuar of De III 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural ⊏cident work?
1 Yes 2 No 5 Pending Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗜 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ortifle 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) -

Demetrice James Catevenis 3001 Hospital Drive Cheverly, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 1315 <u>Myrtle Mae Thomas</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛣 F Months Days Min Hours 9-1-1921 Yrs Ohio Director 89 295-16-1217 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b County Director Baltimore 1 X Yes 2 No Md. 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 21205 5176 Wright Avenue Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: 3 ₩ Widowed 4 Divorced Specify "natural", other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Glass Co. Packer 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Riley William Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. Md. 21205 5176 Wright Avenue William Masters 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-13-2011 Balto, Md. Gardens of Faith Schimunek Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CNA Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cer 29c. License number 07/09/2011

Registrar

State

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rson who completed cause of death (Item 23a) (Type, Print)

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Woods Pd Parkers le

21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1945 FM Ua ade humas Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annopolis dical 8. Date of Birth (Month, Day, April 15 If Under 1 Year If Under 24 Hrs. Funeral Year) 928 1 **X** M 2 □ F Days Months Hours Maryland 215-22-3374 83 **Director** Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🄀 No Anne Arundel Crofton 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral USA 21114 1616 Earlham Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 1ega1 attorney 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline Katherine Brown Wade Purcell Thomas Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 136 Round Bay Rd; Severna Park, Maryland 21146 Wade Thomas III - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Q Other (Specify) 21. Signature of F ray ervice dicensee Way 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hemi Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a curiseduence ut) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the al I be detached fo Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gout CUPD No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed After this certificate has 1 ☐ Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1

Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation
6 Could not be after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical Secrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti certifie 40052024 who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar

2001

medical Parkway

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08^{ay} 2011 July Dolores Ann Velten 9:57 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County St. Joseph Medical Center Towson Social Security Number 8. Date of Birth Funeral 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Min onth, Day Year) C. 04, 1933 214-26-3591 Hours Director 77 Baltimore, MD. Dec. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Baltimore County Direct Maryland Sparks 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country?
United States 10f. Zip Code 3 Old Forge Garth Funeral 21152 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 c -4 or 5+1 the Communications Veterans Adminis. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James E. Cumbest Elsie H. Blunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Mr.Ernest Velten (Son) 3 Old Forge Garth Sparks, Maryland 21152 20a. Method of Disposition
1 □ Burial 2★ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a Department of I Important: If ite any injury or ot cation - City or Town, State (Harford County) Friday, Evens Fueral Charlet and 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Cremetion Services, Inc. July 15,2011 21. Signature of Funeral Sprvice Licensee Jeffrey L. Gair, Sr. O. P. 22. Name and Address of Facility Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. El ter ne disease or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final disease or condition Onset and Death Physician ouns Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury and-tran that initiated events resulting in death) Last burial-t physician Physician/Medical requires that the death certificate be Box 68760 the attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy in the past 12 months
1 Yes 2 No 5 Other (specify) Month detached the Unknown g 🗌 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed bluoria r een 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an he law age 2 s has autopsy perform te certific 25. Was case referred to medical or Attending Physician; ector. of Vital æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA this n 24 hours after death.

e Funeral Director: After the bleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 530 WORTHER AVE 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:20 AM Marcella F. Soi Van Horn Medical 4a. Facility Name (if not institution, give street and nun **Examiner** 4c. County of Death Ko Seda 1 20 quane Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🛣 🖹 Hours 12-4-1952 Country) 213-62-8157 Director 58 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director MD Baltimore 1 Tes 2 X No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5521 Ritter Avenue, Apt. 21206 USA or items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 XMarried ģ 1 Yes 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural", 3 - Widowed 4 - Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Floral Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph M. Kelego Arletta Gail Crites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Casey Phillips - Daughter 157 Bennett Road, Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🖔 Cremation 3 🗀 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 7-12-11 Glen Burnie, MD Signature of Funeral 99 Bradley-Ashton Funeral Home 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner minan Esquentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Day Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2 After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours aiter death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 9000

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Gerald William Volker 20 MIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Med. Glen Burnie Center 5. Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 4/15/1960 217-78-4897 Director 51 DC Lisual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Anne Arundel Severn 1 ☐ Yes 2XXNo 10e. Street and Numbe 10f Zin Code ō 10g. Citizen of What Country? Funeral 23a 1715 Long Tree Court 21144 USA items 2 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2XX Married ò þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. White Specify "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working th and Mental Hygiene.
7 is marked other than "
traumatic event, the Mec life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Office Chief NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert Leo Volker, Sr. Melva Jean Summers permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elaine Regena Volker 1715 Long Tree Court Severn, MD 21144 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 7/13/2011 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signa of Funeral Se M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as he ourial Physician/Medical te 687 IF FEMALE signed by the attendin 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death? certificate Yes the Hospital or Attending Physician: Division of Vital the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Matural 5 Pending after death. 2 No Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Rractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar 29d. Date signed Month. Day. Year. who completed cause of death (Item 23a) (Type, Prin 30. Name and address of person

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

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			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death		
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	Examin	er	4a. Facility Name (if not institution, give s FUURE CARE	Homewoo	od	b. City, Town, or	Location of Death RALHIN If Under 24 Hrs.		Ic. County of Dea	th thplace (State or Foreign		
	Funeral Director		5. Social Security Numb 209 6. Security Numb 209 1 C	7. Age (In yrs. Ia		Months Days	Hours Min.	Adamsh Day Vace	933	tilplace (State or Foreign buntry)		
	iryland a-f show ied at	Director	10a. State 10b. County	1 '	7, Town or Locat	ion MORC				10d. Inside City Limits 1 Yes 2 No		
	ith the Ma 23a or 28a st be notif		10e. Street and Number 1123 N. C	oxoline 54		10f. Zip Code		10g. (Citizen of What C	ountry?		
980	within 72 hours after death with the Maryland jiene. Itan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at.	by		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	if Ye	s Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black		
21215-0036	n 72 hou e. an "natu Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Seconday (0-12)		(Give kind life. DO l	VOT use retired)	during most of work	ing	Kind of Business			
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Maryland	I and 2 should be filed v f Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Typ) 18RESH Kam		19b. Mailing		and Number or Rura Broadu	al Route Number, City	or Town, State, Z	ip Code) 1. 21213		
re,	0		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. P	lace of Disposit				Location - City o			
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Dongtion 5 Other (Specify 21. Signature of Funeral ervis Licesee	M.	+ Carn		eter 7/	15 /11 /3	epolitus	chapel P.C.		
Ba	Depa Impo any i		1 hughest	uller	10	639 N.	Broad	way Bal	to. md			
7	Physician/ Medical	2 4	239 Part 1. Epter the disease, or compi shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	ications that caused the death e cause on each line. a. Due to (or as a consequ	rotic					Approximate Interval Between Onset and Death		
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	executed an and rial-transit	Examiner	Cause (Disease or iinjury that initiated events	c								
90			resulting in death) Last									
Box 68760	Attending Physician: The law requires that the death certificate be ar death certificate be ar death. After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregna n t at time of c	aldeath 3 🔲 🛭	Ectopic pregnan Other (spec <i>ify</i>) _		23d. Date of d Month	elivery Day Year			
ls, P.O.	uires that th n signed by	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the unc	derlying cause gi	ven in Part I.	1		to the cause of death? Probably 4 Unknown		
Division of Vital Records,	sician: The law req certificate has bee irector, page 2 shou	Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of		
tal F	ysician: The second sec	Be C	25. Was case referred to medical examiner?				lace of Death (Chec		NO TEST			
f Vii	Physic this ceral dire	은	1 Yes 2 No	lospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatient 28b. Time of	3 DOA Oth	4 Mursing H	ome 5 Residence		ecify)		
o uo	ending eath. or: After ne fune	Certificate;	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	injury	worl	k?] Yes 2 □ No	Edd. Bedering Heaville				
>	5 # E C		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
The second of the cause (s) and the second of th										e cause(s) and manner stated.		
									Date signed (Mor	oth, Day, Year)		
	1812		30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Type, Prin		059056		7/12/1			
			Dalicet Salux	MO 702	- Wist	yon	St Bei	+ NO 2	1211			
	Sta Registr		31. Date JUL Month, 2 2011	32. Registrar's Signa	ture No.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend#5perinf 9917 7-15-11 d.o.
State of Maryland Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month July Day Physician/ Wade H. Wheeler Sr. 2011 1:20 \mathbf{P}^{M} 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 67 Spring Time Way Parkville Baltimore 219-26-19404 216-26-9404 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 □ F (Month, Day, Year) July 10,1938 South Carolina Director 73 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Parkville Baltimore Maryland 1 ☐ Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 67 Spring Time Way 21234 **USA** permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked others. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces þ 1 Never Married 2 Married Yes 2 🔀 No 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mass Transit Bus Driver 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Howe Jesse Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 67 Spring Time Way Baltimore, Maryland 21234 Wade H. Wheeler Jr. (Son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gardens of Faith Cemetery 7/13/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address, of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, W Maryland 21221 Falt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHRUSCHerofic DISEASE Physician UASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death the g Unknown g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS LABETES 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ERTEN SIAN 24a. Was an autopsy performed? 1 Yes 2 No has e 2 s certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 🔀 No 1 🗌 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after deau..

e Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 [only one 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) 12/2011 30. Name and address of berson who completed cause of death (Item 23a) (Type, Brint)

LIVA PFE FFEL m.D. 6718 LIDGE BO BAHT m.26 31. Date filed (Month, Day, 32. Registrar's Signature

State

Registrar

1 2 2011

DC

Year

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, After this 28a. Date of Injury FOUND: 1 Natural Subject shot FOUND: 5 Pending 1 Yes 2 ✔ No Director: Jul 7, 2011 0015 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street end Number or Rural Route Number, City 6 Could not be or Town, State) 1927 18th Street Southeast Apt #2, Washington, DC determined (Specify) Sidewalk 24 hours 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 7, 2011 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month Day State

Registrar

11-04947 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charles Edward Wolford 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month July 2, 2011 Year 1540 hrs **Medical Examiner** WOLFORD **EDWARD** CHARLES 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Leonardtown St. Mary's Hospital 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Foreign WASHINGTON Months Days Hours Director 46 577-88-9986 1 X M 2 F AUG. 20 1964 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 1 X Yes 2 No LEXINGTON PARK ST. MARY'S hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number IISA 21925 D WEEPING WILLOW LANE 20653 Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 Yes 2 X No ö BLACK f Yes, Give Year 1 Yes 2X No specify: Specify: 3 Widowed 4 Divorced ≦ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Baltimore, MD 21215-0036 GOVERNMENT CUSTODIAN 12th of Health and Mental Hygiene.

If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHARLES M. WOLFORD OLA L. STEPHENS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653 21925 D WEEPING WILLOW LANE LEXINGTON PARK, MD WOLFORD/WIFE SOPHIA 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from S 7/9/11 HARMONY CEMETERY LANDOVER, MARYLAND Donation 5 Other Specify 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC 21 Signature of Funeral Servi 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Approximate Interval 23a. Part I. Enter the discussion of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and √ /Medical a Staphylococcal lleopsoas abscess and sepsis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and trar Physician/Medical AMENDED 23a, pt. II, 27, per me, g917 7-25-11 sm attending physician or use as the burial X UNPENDED certificate be 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á

Division of Vital Records, P.O. Box 68760, ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

Interal Director: After this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial – transit

within 24 hours a To the Funeral I

DHMH 17 Rev 1/2001

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Completed

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Medical

1 Yes 2 V No 3 Probably 4 Unknown Diabetes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

July 3, 2011

Registrar

29b. Signature and title of certifie

Victor Weedn MD JD

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

lee

Assistant Medical Examiner

32. Registrar's Signatur

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

show

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar certificate this After t Director: Funeral within 24

State Registrar

29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Jennifer Castello Date filed (Month, Day, Year)

1 2 2011

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

515 Brightfield Road, Lutherville MD 21093

29a. Certifier

(Check only one)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ 1830 PM Jul 2011 Medical Facility Name (if not institution, give street and number) Town, or Location of Death County of Death 4ç. Examiner nemori nion timore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min. Country) 3022 1 M 2 MDDirector Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Battimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 Flierslie Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Completed by 1 🗆 Yes 2 🗖 No Specify: **Black** Specify. 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Home Be 18. Mother's Name (First Middle, Maiden Surname) Father's Name (First, Middle, Last Baynham 2 race Corbin 19a. Informant's Name/Relationship (Type, Print) . Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) Sti Balto. Kenny <u>Jaene</u> nod of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mem. PK. 21. Signature of uneral Service Lice. 270 Fredhillon Pess Balto. mo 21229 March F/H 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final pulmon ary d15 EA OBSTYUCTIVE Ph_sician/ stronic disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by neart 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy 2 1 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗆 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer work? iniury 1 Natural 5 Pending ☐ Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direc determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2011 MY 5102 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 North CHArles on m. D WY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wilhelm Year Physician/ Month William 1 M 110 July 2011 Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours 1 ★ M 2 □ F $^{th}1^{D_{ay}}$ 1929 Director Jan 215-28-4511 Usual Residence of Decedent 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Eldersburg MD Carroll 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 6504 Panorama Dr. 21784 an "natural", or items Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1★ Yes 2 □ No 1950If Yes, Give
Year or Dates. 1954 Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. White Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Wilhelm Energy Services Fuel Oil Dealer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1.
Department of Health and Mental Important: If Rem 27 is many injury or other and Mental | ည Mary L. Warner William F. Wilhelm, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alva L. Wilhelm (Wife) 6504 Panorama Dr. Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Sykesville, MD ake View Mem Park 7/13/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory,
1212 W. Old Liberty Rd. Winfield, MD 21784

Approximation arrest 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death End-Stage Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Exam requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death signed by the a 2 No 1 | Yes 2 L 9 | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 2 No Yes 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Be 25. Was case referred to medica 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Sother (Specify) Other: 1 Yes 2 No မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\text{Yes} 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or A after the Hospital Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MSKWapakneM.C 00057465 D.0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 2835 Smin

DHMH 17 Rev 7/2009

State Registrar RajapakseMD

5-203

-	For State	State of	Marylan		rtment of F tificate of L	Health and I	Mental Hy	/giene	011	22171
_	Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	incate of L		2. Date of De	Reg. No.		3. Time of Death
an/ cal	Helen D. Winkeln	nan					July 7	7, 201	Year	2:00 P M
ner	4a. Facility Name (if not institution, g		er)		4b. City, Town, o	r Location of Death		1	County of Death	•
	Shady Grove Adve				Rockvil.				ntgomery	
	310-18-8799	5. Sex 1 □ M 2 🗶 F	Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di November	rth ay, Year) 1, 19	9. Birthr Coun 1 nd i	place (State or Foreign try) ana
b	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation				1	0d. Inside City Limits
Director	Maryland Montgo	mery	Rock	ville						1 ☐ Yes 2X No
	10e. Street and Number				10f. Zip Code			10g. Citizo	en of What Cour	ntry?
Funeral	7053 Wolftree La	ne			20852			Unite	ed State	S
	11. Marital Status	12. Was Decede Armed Force	s?		as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	- 14	4. Race - Americ Black, White,		
d by	1 ☐ Never Married 2 ☐ Marrie 3 【XWidowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Date		1	☐ Yes 2 🛣 No	Specify:		S	pecify: Whit	
Completed	15. Decedent	s Education	5.		ent's Usual Occup				d of Business Inc	
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To B	17. Father's Name (First, Middle, La	st)				18. Mother's Nan			,	
-	Arthur Meyer					Lillian				
23	19a. Informant's Name/Relationship			1		and Number or Ru		-		
	Peter A. Winkeln 20a. Method of Disposition	nan/Son	20b. P		H1alean ition (Name of	Way, Nor	Date		riaryian ation - City or To	
	1 Surial 2 Cremation 3 4 Donation 5 Other (Sp		ate C	emetery, crem	atory or other plac				-	
	21. Signature of Funeral Service Lic		IKoc		Cemeter		_		ington,	
10	Haran M. C.	12. 0	M0153	0 1755	pert A. Pum 7 Wisconsi	iphrey Fune in Avenue,	ral Home, Bethesda	Bethe Marvl	sda-Chevy and, 2081	Chase, Inc.
	23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that cau	sed the death						,	Approximate
) yz	Immediate Cause (Final disease or condition	*		lmone	ivil av	rest				Interval Between Onset and Death
	resulting in death)	Due to (or	as a consequ	ence of):	iry ar	, 0, 1				
_	neumonia									
Examiner	if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying									
xal	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):									
	resulting in death) Last	Due to (or	as a consequ	lence oi):						
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Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnal					20	3d. Date of delive	an/
icia	in the past 12 months? 1 Yes 2 No	4 🗌 Pregna	th 2□Feta nt at time of d		Ectopic pregnand Other (specify)	СУ			Month	Day Year
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by P	Part II. Other significant condition	s contributing to deat	th but not resi	ulting in the ur	derlying cause giv	ven in Part I.	23e. Did	tobacco use	e contribute to th	ne cause of death?
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2	1 Yes 2 No			ER/Outpatient	3 DOA Othe	er: 4 🗌 Nursing H	lome 5 Res	idence 6	Other (Specify)
ate:	27. Manner of Death1 → Natural5 □ Pending	28a. Date of (Month,	injury <i>Day, Year)</i>	28b. Time of injury	28c. Injury	?	28d. Describe	how injury o	occurred	
tific	2 Accident Investiga 3 Suicide 6 Could no	the -	Indiana At Inc			Yes 2 No				
Certificate:	4 Homicide determin		etc. (Specify)		et, factory, office			Street and I wn, State)	Number or Rural	Route Number,
Medical	(Check 2 Medical Ex		of examination	and/or investi	gation, in my opinio	on, death occurred a	at the time, date	and place, a	and due to the ca	use(s) and manner state
Σ	only one) 3 ☐ Certifying N 29b. Signature and title of certifier	lurse Practioner: To	the pest of my	KITOWIEUGE, O	29c. License		ice, and due to t		signed (Month, i	
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	D - 1.	Mada	VC -	I_A/D	1 2 00	07512	I	Jul	Y 7, 2	011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Madan Bangalore, MD 9901 Medical Center Drive, Rockville, Manyland 20850

31. Date filed (Month, Day, Year)

JUL 12 2011

June A. James

100 July 7, 2011 REBECCA CHOI WONG Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		S	State of	Maryla		•				/lental Hy	/gien	e ₂ n		221	72
		Registrar 1. Decedent's Name	- /First Middle	a Last)				Certi	ficate of	Dea	itn	2. Date of D	Reg. N	10	ŧ i	3. Time of	Death
Physicia	n/				Chan	Wong						Month July		2011	Year	11:06	
Medic Examin	Rebecca Choi Chu Chan Wong Kaminer 4a. Facility Name (if not institution, give street and number)							4	1b. City, Town	, or Loca	ation of Death	1 0 0 1 7		lc. County	of Death		, 21
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Funeral		5. Social Security No		6. Sex	7. 1 2 X F	Age (In yrs.		// N	If Under 1 Ye Months Day	8. Date of B (Month, D May 2	irth ay, Year	0.5.1	9. Birth	nplace (State or intry) ina	Foreign		
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should and N is ma		19a. Informant's Na	ame/Relations	ship (Type, i	Print)		19b.	Mailing	Address (Stre	et and N	Number or Rur	al Route Numb	per, City	or Town, State, Zip Code)			
nd 2 sealth m 27		Elle Won				-				y La	ne #60	6, Beth				and 208	14
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 X Burial 2		3 ☐ Ren	noval from S	tate	cemetery	y, crema	tion (Name of tory or other p		Ju1	y 16,	1		•	Town, State	
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permit Depar Impor any in	Ų	21. Signature of Fu	ineral Service	Licensee	hier	М0	1173	Rőb 300	ert A.	umph	rey Fund	eral Hom ue, Rock	e, Ro	ockvil Mar	le, I	Inc. 1 20850	
		23a. Part 1. Enter t	the disease, o	r complica	tions that ca	used the dea	ath. Do no									Approximat Interval Bet	
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ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)													ate of del onth	-	Year
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pital cours at eral D		29a. Certifier	Contifuin	a Physicia	un. To the ha	et of my kno	wledge o	death or	cured at the t	ime date	e and place a	nd due to the	cause(s)	and mann	ner as sta	ated	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	l edical	(Check 2	2 Medical	Examiner:	On the basis	of examinat	ion and/or	r investig	gation, in my o	oinion, de	eath occurred	at the time, date ace, and due to	e and pla	ace, and du	ue to the o	cause(s) and ma	inner stated
To the vithin To the Comp	Σ	29b. Signature and			00	1	11	1	29c. Lic		_		1			h, Day, Year)	
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		30. Name and addr		who comp	oleted cause	of death (Ite		Type, Pri		nter	Drive	Rock	will	e, M	an	land 24	0850
Stat	re.	31. Date filed (Mont	th, Day, Year)			gistrar's Sign		1		11.	01100/	704	- + 11	-/			-
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1-05061	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.															
Cynthia Womack	State of Maryland / Department of Health and Mental Hygiene Certificate of Death											2217				
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Physiciai Medical Examin											Month July 7, 2	Da	y Year		1036 hrs	
		Cynthia V. Womack 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death											4c. County o			
		3718 Ravenwood Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.												N/		
Funeral Director	- 1	5. Social Security Number 218-90-9180	6. Sex	100	-		If Under	Year Days		_	8. Date of 6/7/	•	1	Foreig		
	L	Usual Residence of Decedent	1 M 2 K F	4	6	Yrs					0/ //			Col	intry) IID	
/ aoy		10a. State 10b. County		10	Oc. City, Town										10d. Inside City Limits	
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21215-0036 suld be filed within 7 Mental Hygiene marked other thao e eveot, the Medica		17. Father's Name (First, Middle			1	_		18					en Surname)			
1121 Id be fil fental narked eveot,	ш	Willie Vandr 19a. Informant's Name/Relations			140	Nh. Basilina	. A did		-	15-75-	ca Ar					
Baltimore, MD 21215-003(permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Importaot: If item 27 is marked other that jointy or other fraumatic evost, the Media		David Womack	, , ,, ,										City or Town			
e, hand I and Health		20a. Method of Disposition			20b. Place		ition (Name				Date		c. Location -			
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Baltimore, permit. Pages I ar Popartment of Hes Important: If ites Important: If ites injury or other tr	1	21. Signature of Funeral Service				22. N	lame and Ad	dress	of Facility	0 1	. 1		1.1	Λ	BALLIMINER	
	1	23a. Part I. Enter the disease, or	complications that	caused the	a death. Do n	19/	Louch	F. 1	H. 1	ast	110) }	JORIN	HUR	Md 21206	
Physician /Medical	1	failure. List only one cause	on each line.	Caused (III	death. Do n	iot enter ti	ie mode ord	iyirig, s	uu i as ca	ardiac oc r	espiratory a	arrest, s	snock, or near	t	Approximate Interval Between Onset and Death	
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequ	ence of):										334.	
	_	Sequentially list conditions,	b Due to (or as		of\:											
	ا⊒	if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated	C.													
ecuted and transit		events resulting in death) Last	Due to (or as	a consequ	ience of):									- 17		
executed an and al - transi	<u>평</u> 누	UNPENDED	d AMENDED			· · · ·										
ox 68760, sath certificate be eath certificate be eath certificate at the burial for use as the burial for use		F FEMALE:	23c. If yes	outcome	of pregnancy							2	23d. Date of d	lelivery		
certification	San	3b. Was decedent pregnant in to past 12 months?	I I L LIVE			-=	tal death	3 [Ectopic	pregnanc	у		Month	D	ay Year	
Box 68760, a death certificate by the attending physic of for use as the bur	Š	1 Yes 2 No 9 ✔ Un				5 Oth	ner (Specify	_								
P.O. E	<u>a</u>	Part II. Other significant condit	tions contributing	to death b	ut not resultin	ng in the u	nderlying ca	use giv	ven in Par	rt I.					he cause of death?	
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/ital	ğί	25. Was case referred to medical examiner?	Hospital:	Inpatient	2 FR/0	Outpatient			Man -	Check on		Pasi	dence 6	Othor	Score	
ing Phy ing Phy After th	<u> </u>	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b.	Time of Ir			at Work?	28	3d. Describ	e how in	njury occurre	•	Scelle	
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lospita hours ly fille	4 Homicide determined (Specify) Townhouse / Rowhouse 3718 Ravenwood Avenue, Baltim 29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st one one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
thin 24 the Fi	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Constituting 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Constituting 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Constituting 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											d. cause(s)				
and manner stated. 29c. License number 29d. Date sign									d. Date signed	d (Mon	th, Day, Year)					
Carol Hellan O.C.M.E. July 8, 201									ly 8, 2011							
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Stat	fg 3	Carol Allan, MD As 1. Date filed (Month, Day, Year)	sistant Medical		Signature		inore Str	eet, E	aitimo	re, MD	z1223		:			
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Registrar

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Seorge Everett Wil	1- For State	St	ate of Maryla		ment of icate of		Mental F		20	11 2217
Physician/ Medical Examine		s Name (First, Midd		1 1,1.	,		<u>.</u>	2. Date of Dea Month	Day Year	3. Time of Death 1616 hrs
Visition Examino	4a. Facility N	eorge ame (if not)institution tockyard Road	EVERE To on, give street end nu	umber)	S01V 4	o. City, Town, or L Salisbury	ocation of Deat	June 30,	4c. County of Wicomico	Death
Funeral Director	5. Social Sec		6. Sex	7. Age (In yrs. last I	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Min		rth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
OW ABY	10a. State	nce of Decedent 10b. County	,	10c. City, To	, /				//_/_/\	10d. Inside City Limits 1 Yes 2 No
nith the Maryland 1.23 or 28a-f sho notified at once.	10e. Street e		omico	Road	1./1.5 b	<u>U/U</u> 10f. Zip Code 2/8	22		log. Citizen of Wha	
er death w , or items r must be	11. Marital Si	Married 2 M	arried Armed For 1 Yes	2 No	If Ye	Decedent of Hisps, specify Cuban,	panic Origin? (S Mexican, Puert			American Indian, Black, etc.
5-0036 led within 72 hours aft 1/giene. ofter than "natural" the Medical Examine Completed by	45 Decede	nt's Education (Spe y/Secondary (0-12)	or Dates: cify only highest grad	de completed) 16	a. Decedent	s Usual Occupationst of working life.	on (Give kind of DO NOT use re	tired)	16b. Kind of Busi	
21215-0036 uld be filed within 73 Mental Hygiene. marked other than c event, the Medical To Be Comple	17. Father's I	Name (First, Middle,	Last)	ikon		HANGY	MAN 8.Mother's Nam Fay		SELF- Maiden Surname)	employed
ind 2 sho ealth and com 27 is	Faue	nt's Name/Relations	hip (Type, Print)	her	8504	Address (Street 30 High ion (Name of Cem	and Number/or Wall / 7.		nber, City or Town, of 8, Vw	State, Zip Code) CE FL 32097 ity or Town, State
Baltimore permit. Pages 1 a Department of H Important: If it injury or other it	4 Donat	2 Cremation ion 5 Other Sa of Funeral Service	Removal froecify:	om State Atlan	vhe 22. Na	er place) / ewa for ime and Address	U 7 Facility 3	-8-2011 Tradley	GILEN BU	TWETAL COME
Physician /Medical	failure. I	nter the disease, or list only one cause ause (Final disease		aused the death. Do			uch as cardiac	or respiratory arr	0 213	33
≟xaminer ō	or condition r	resulting in death) list conditions,	Due to (or as a	consequence of):	0020	.ovasca1o	.r bagge			
executed an and all transit all transit cal Examiner		Undertying Cause njury that initiated ing in death) Last	d.	consequence of):						
di nata		edent pregnant in th	23c. If yes,	23a,27, per outcome of pregnand oirth	су	917 7-13	-11 sm	ancy	23d. Date of do	elivery Day Y ear
o.O. Box 68760 that the death certificate by the attending physical deached for use as the buby Physician/Me	1 Yes 2	No 9 Uni	4 Pregn g Unknown g contributing to		5 Oth	er (Specify) derlying cause giv	ven in Part I.	23e. Did to	obacco use contribu	ate to the cause of death?
- 8 go 8 -								24a. Was	an 24b. We	Probably 4 Unknown are autopsy findings available or to completion of cause of
of Vital Records, ng Physician: The law requirement this certificate has been signeral director, page 2 should the TO Be Completed in: To Be Completed	25. Was case	referred to medical					of Death (Check	1 ✓ Yes		ath? Yes 2 No
C = . ~ 4 5	examiner 1 Ye 27. Manner o 1 X Natur	s 2 No f Death al 5 Pend	28a. Date (Month		Outpatient Time of Inj	ury 28c. Injury			Residence 6 🗹	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune	2 Accident 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route or Town, State)									
Di To the Hospital within 24 hours 27 the Funeral I completely filled	(Check only one)	Certifying Fr	nysician: To the bes miner: On the basis of and manner s	of examination and/o			death occurred		and place, and due	to the cause(s)
	1	Short	masulf who completed caus	se of death (Item 23a		O.C.M			July 1, 2011	(Month, Day, Year)
State	Melissa	Brassell, MD		dical Examiner	•	Baltimore Str	eet, Baltimo	ore, MD 2122	23	
Registrar DHMH 17 Rev 1/2001		JUL 12	2011	me s	RIGINAL	K)	-			
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		_	For State Registrar		ıryıar		rtificate of L			Reg. No.	Martin and a second	22175		
1	Physicia Medic		1. Decedent's Name (First, Middle, Las Frank M.	Wilhel	m,	Jr.			2. Date of De July 1	.0, ^{Day} 011	Year	3. Time of Death 9:20 p ^M		
	Examin	er	4a. Facility Name (if not institution, give Stella Maris	street and number)			4b. City, Town, o	r Location of nium	Death	4c. County Ba	of Death	ore		
	Funeral Director		5. Social Security Number 214-03-0294 6. Sex 1 X M 2 G F 97 Yrs. 7. Age (In yrs. last birthday) 97 Yrs. 1 V Months Days Hours Min. February F									place (State or Foreign 7)and		
	Maryland 8a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltim	ore	10c. Ci	ty, Town or Lo			-		1	0d. Inside City Limits 1 Yes 2 X No		
	with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 8810 Walther Blv	d, Apt. 16	507		10f. Zip Code 212	34		10g. Citizen of V		ntry?		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Journathart. If the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۾	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc. Specify: White		
215-(ו 72 hou an "nati Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)			(Give	dent's Usual Occup kind of work done OO NOT use retired)	ation during most o	16b, Kind of B	16b. Kind of Business Industry				
21	withir giene ner th t, the			2		Bu	siness Ow	ner		Manufa	cturi	ing		
yland	ld be filed Mental Hy arked otl atic even	To Be	17. Father's Name (First, Middle, Last) Frank M.			's Name (First, Middle, Edna	Maiden Surname Ha	-						
, Mar	1 and 2 should I of Health and Me item 27 is marl other traumati		19a. Informant's Name/Relationship (7) Edna W. Engle-da						or Rural Route Number Bel Air, N			Code)		
Baltimore, Maryland 21215-0036	Page 1 al ment of Hi ant: If itel ury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		1 4	Place of Dispo cemetery, crea Loudon	position (Name of matory or other place Park	ce) 7	Date 7/16/11	20c. Location - Balti	-			
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	^{ee} William	G.	Dau 2			Ruck Towson, N			ome, Inc.		
5	Physician/ Medical		23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused ne cause on each line a. PROSTAT Due to (or as a	E CA	NCER	er the mode of dyir	ng, such as ca	ardiac or respiratory ar	rest,		Approximate Interval Between Onset and Death		
0	be executed RXT sician and PXT e burial-transit and	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initigry that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.										
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 1 4 Pregnant at 9 Unknown	al death 3	Ectopic pregnand Other (specify)	су	te of deliventh	of delivery n Day Year					
s, P.O.	iires that th signed by Id be detac	d by Ph	Part II. Other significant conditions of	ontributing to death be	at not re	sulting in the	underlying cause gi	ven in Part I.	23e. Did t			ne cause of death?		
Division of Vital Records,	The law requate has beer bage 2 shou	Somplete							24a. Was auto perfo 1 \(\sum \) Yes	psy ormed?	Were auto prior to co death? 1 ☐ Yes	psy findings available impletion of cause of		
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f Vi	Physi this or	2	1 ☐ Yes 2 😿 No 27. Manner of Death	1 Inpatie		ER/Outpatie	ont 3 DOA Oth	4 ∐ Nur	sing Home 5 Resid	dence 6 X Oth		HOSPICE		
ou c	nding ath. r: After e fune	icate	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day		injury	worl	⟨? Yes 2 □ N		ion injury cocur	-			
Division	al or Atters after des	Certificate:								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 Medical Exami	ner: On the basis of ex	aminatio	on and/or inves	stigation, in my opini	on, death occ	ace, and due to the ca urred at the time, date a and place, and due to th	and place, and du	e to the ca	use(s) and manner stated.		
	To t with To t		29b. Signature and title of certifier	GRNT			29c. Licens	e number		29d. Date signer	d (Month,	Day, Year)		
			30. Name and address of person who could JACKIE JONES, CI				Print) LLEY RD.	ттио	NIUM, MD 2	1002				
r	Stat	e	31. Date filed (Month, Day, Year)	32. Registra			West No.		MIURI, MU Z	1073				

JULY 10, 2011 9:20 p.m.

FRANK WILHELM

State Registrar

11595

DHMH 17 Rev 1/2001

31. Date filed (Month,-Day, Year)

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

2011

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 July 10, Physician/ Margaret Geraldine Williams 1:30a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 700 West BelAir Avenue Apt. 307 Aberdeen Harford Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1922 West Virginia Min. July 13 Hours 1 □ M 2 🕱 F 295-38-560 88 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be a Funeral 700 West BelAir Ave., Apt 307 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other the second Homemaker In Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Dennison Naomi Herrod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa E. Stupi (daughter) 824 Maxa Road, Aberdeen, Maryland 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖳 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 7/11/2011 West Chester, PA R.A.Ferris & Company 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final breast cancer Pnysician/ m etastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ☐ Pregnam.
☐ Unknown Pregnant at time of death 5 Other (specify) the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? 1 Yes 2 No death? 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation the Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 24 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 000048050 7 1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Prashant Shukla, NO 15 5. Parke St 15 s. Parke St. #400 Aberleen, M9 31. Date filed (Month, Day, 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 PM 93 Timothy Darnell Avery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Agnes Hospital Balhmore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Pay Hours Director 217-96-8483 30 MD Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔽 No MD Baltimore Randallstown 10e, Street and Numbe 10g, Citizen of What Country? Funeral 3706 Nauset Place 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Ares Protective Service Security Officer or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Avery Jr. Catherine E. Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 Nauset Place, Randallstown, MD 21133 Deon E. Avery/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 and Department of It Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Arbutus Memorial Park 7-15-2011 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signature of Funeral/Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Pancreah tis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Day Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pishess sgadrum 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s certificate has 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in muralism Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the I within 2 only one) 29d. Date signed (Month, Day, Year) DD 66251 6,2011

State Registrar 900 CATON

AUENUE

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JR

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 1.22 AM James Ethan Aggrey Appiah 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) M If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Min Yrs 6-18-2011 one Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MD Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 10011 Antium Way 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 Yes 2 If Yes, Give Year or Dates: 2 **X**No 1 ☐ Yes 2 XNo Specify: African-American 3 🗌 Widowed 4 🗌 Divorced 16b. Kind of Business/Industry n/a 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline Martinson Nana Kofi Appiah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Martinson/ Mother 10011 Antium Way, Owings Mills, MD 21117 20a. Method of Disposition Marial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Donation 5 Other (Specify) Woodlawn Cemetery 7-9-2011 Woodlawn, MD of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ems 23a or 28a-f sh r must be notified a

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is marked other than "natu aumatic event, the Medical

and Mental

nt of Health a : If item 27 is or other tra

permit. Page Department or Important: If any Injury or once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and as the burial-tran 24 hours after death e Funeral Director: / bletely filled in by the within 2 To the I

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition	a Multisystem org	an failure			Onset and Death					
	resulting in death)	Due to (or as a consequence of): Bowel perforate	, ,								
Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):									
xamir	cause. Enter Underlying Cause (Disease or injury that initiated events	с									
alE	resulting in death) Last	Due to (or as a consequence of):									
edic		d									
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 23d. Date of definition of death 3 Ectopic pregnancy 23d. Date of definition of death 5 Other (specify) Month Month 1 Month										
ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										
Complet				24a. Was an autopsy performed?	prior to death?	ntopsy findings available completion of cause of 2 No					
Be (25. Was case referred to medical examiner?		26. Place of Death (Check only one)								
일	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Dutpatient 3	□ DDA Other: 4 □ Nursing Ho	ome 5 - Residence	6 Other (Spec	cify)					
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation										
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Run City or Town, State)										
dical	29a. Certifier (check only one) 1 Certifying Phy 2 Medical Exam	/sician: To the best of my knowledge, death occ iner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place gation, in my opinion, death occu	, and due to the cause urred at the time, date a	(s) and manner as and place, and du	s stated. e to the cause(s)					
Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Monti	h, Day, Year)					

120066628

600 North Wolfe St, Baltimore, MD, 21287

6 2011

Registrar

State

ANIA

Name and address of person who completed cause of death (Item 23a) (Type, Print) DEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:20 P. M July 8, 2011 Walter Joseph Amass /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 1309 McCurley Avenue Catonsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 X M 2 □ F 215-24-3435 12, 1927 Maryland 83 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Wulcal Evincient into the Locality of attention of the Company of the Co 1 ☐ Yes 2 ☐ No Directo MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1309 McCurley Avenue USA 21228 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 □ No If Yes, Give Year or Dates: 1944–46 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Post Office Postal Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Loretta Smith Abraham I. Amass ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 704 Hilton Avenue; Catonsville, MD 21228 William Amass Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page:
Department of Important: If any injury or once, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery | 7/12/2011 Baltimore, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Sign Ture of Funeral Service License MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or omplications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Do not enter the mode of dving, such as cardiac or respiratory arrest, SOPHAGEAL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Directo (or as a messic) vince of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-1 P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day for 1 Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗋 Accident after death Director: the 6 ☐ Could not be n 24 hours after de: ne Funeral Directo bletely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License-number 29b. Signature and

Registrar

State

he and address of

Soltimore MD

11-05149 Raquel Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Raquel Brown		Si 1- For State Registrar	tate of Maryla		artment o <i>rtificate o</i> i		nd Mental F		201	1 22181
Physicia	an/	Decedent's Name (First, Midd		D				Date of Deat Month	Day Year	3. Time of Death 1234 hrs
Medical Exami	ner	Raque1 4a. Facility Name (if not institution		Brown	— т	4b. Citv. Town, o	or Location of Dea	July 10, 20)11 4c. County of De	
		St. Agnes Hospital	., 0	,		Baltimore				
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye		_	th(MM/DD/YYYY) 9.	coion
Director		557-61-1775	1 M 2 X F	43	Yrs	Months Da	ys Hours Mi	ⁿ Oct. 19	9, 1967	Country) CA.
any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locat	ion				10d. Inside City Limits
		MD N/A			timore					1 Yes 2 No
aryland 8n-f show at once,	cto	10e. Street and Number		Lbai	LIMOTE	10f. Zip Code		10	og. Citizen of What C	country?
ith the Maryland 23a or 28a-f sho notified at once.		1040 Parksley	Avenue			2122	23		USA	
h with	Funeral Director	11. Marital Status		cedent Ever in U.			ispanic Origin? (:	Specify Yes or No-	- 14. Race - Ar White, et	nerican Indian, Black,
or deat	Fun	1 Never Married 2 XM	1 Yes	2 x No			o specify:			ispanic
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003(within iene.	dmo	12	2		Benei	it Spec				Union
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 she injury or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle Charles		elch			18.Mothers Nan Mary	ne (First, Middle, N		rron
212 212 2uld be I Ment in mark		19a. Informant's Name/Relations			19b, Mailing	g Address (Stre	eet and Number or	Rural Route Nur	ber, City or Town, S	tate, Zip Code)
MD d 2 sho lth and n 27 is		Richard A. Brow	wn (Husb						e, MD 212	
ore, s 1 an of Hea If iter		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fr	om State	crematory or ot	sition (Name of co her place)	1	Date	20c. Location - City	
Baltimore, permit. Pages 1 an Department of Hea Important: If iter		4 Donation 5 Other S	pecify:	Me	tro Cre			15/11		e, Maryland
Ball permit Depart Impor		21. Signature of Funeral Service	Licensee						k Funeral more, MD	
Physician	-	23a. Part I. Enter the disease, or		aused the death.						Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		omegaly						Between Onset and Death
SAGIIIIIOI		or condition resulting in death)	Due to (or as a	consequence of	f):					
	ě	Sequentially list conditions, if any, leading to immediate		consequence of	f):					
_	Examine	cause. Enter Underlying Cause (Discase or injury that initiated events resulting in death) Last	C.	consequence of	D:					
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376(ificate g phys s the b	1	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, the	outcome of pregr		tai death 3	Ectopic pregi	nancy	23d. Date of deli Month	very Day Year
Box 6876(e death certificate the attending phy ed for use as the b	Physician/M	past 12 months?	4 Pregn	ant at time of de		her (Specify)				
BO)	h	1 Yes 2 No 9 ✔ Un	a Dougle		eulting in the	indorlying cause	given in Part I	23e Did to	hacco use contribute	to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	2	rust ii. Outer significant condi	Tons Contributing to	J deali Dut Hot re	saditing in the t	anderlying cause	given in r aici.			Probably 4 V Unknown
ords, w require s been si should b	Completed							24a. Was a		autopsy findings available to completion of cause of
ecol ne law te has	틽							autop perfor	med? death	1?
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medica	1			26.Plac	e of Death (Chec			
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ion of tending Pheath. tor: After the funeral		27. Manner of Death 1 X Natural 5 Pen		of Injury , Day,Year)	28b. Time of I	· ·	ury at Work? Yes 2 No	28d. Describe h	now injury occurred	
Attendary death	Cati	2 Accident Inve	stigation 28e Place	e of Injury - At ho	ome farm stree	A		28f Location (S	Street and Number or	Rural Route Number, City
Division ospital or Attent hours after death neral Director: y filled in by the	Certification:		Id not be (Specify)		, iaiii, stro	si, idalory, omoo	ballating, oto.	or Town, S		, , , , , , , , , , , , , , , , , , , ,
E 4 E 9		29a. Certifier (Check only 1 Certifying P	hysician: To the bes						• •	
To the Hos within 24 h To the Fur	Medical	2 🔻	miner: On the basis of and manner s		nd/or investigal			at the time, date		
	2	29b. Signature and title of certific	я				se number .M.E.		29d, Date signed (wontn, Day, Year)
,		30. Name and address of persor	who completed care	se of death (Item	23a)				, , 2011	
ϕ		Donna M. Vincenti, M				W. Baltimore	e Street, Balt	more, MD 21	223	
St Regist		31. Date filed (Month, Day, Year)	32. Re	egistra s Signa	ares					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day George Thomas Binko Jr. July 8 2011 9:42 am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
Mar. 2, Social Security Number 6 Sex 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** Months 1 K M 2 D F ^{Year)} 1928 Maryland **Director** 216-24-6311 83 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 XNo Maryland Harford Bel Air 10e. Street and Number 0 10f. Zip Code 10g, Citizen of What Country? pe ms 23a omnust be Funeral 1405 Saratoga Drive 21014 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. "natural", or ite Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 X Never Married 2 Married X Yes 2 | No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates White th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housing Manager U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Thomas Binko Sr. Mary C. Gattus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clem Mueller / Nephew 714 Scarlett Drive, Towson, MD 21286 injury or other Important: If item any injury 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus! 7-13-11 Dundalk, Maryland Signature of Funeral Service Licens McComas Funeral Home, 1317 Cokesbury Road, , P.A. Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Wale disease or condition resulting in death) UNICHOWN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Englished Programme Cause (Disease or iinjury Examiner Due to (or as a consequence of) and Binko, Seorge that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Dav 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Sinkhown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy 2 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ည ppatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Vatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a 1 withing Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00056296 who completed cause of death (Item 23a) (Type, Print) 500 upper chesapeake Drive Bel Air, MO 21014 Jason Birnbaum 1 3 2011 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY HILDA MARGARET BECKER 20ĬĨ 7:35AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE STELLA MARIS HOSPICE TIMONIUM 8. Date of Birth July 25, 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 - M X X F Months Days Min Hours ^{Ye}1925 Maryland Yrs Director 214~24~9662 **B**5 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 145 Riverthorn Rd. 21220 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Ford Black, White, etc þ 1 Never Married 2 Married Yes XX No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give White XX Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore County Board 12 yrs. College (1-4 or 5+) School Teacher of Education yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Hilda Edna Stumpf William John Peper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Marsha A. Roach (Daughter) Middle River, Md. 2127 Oakland Rd. permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Zion Church Cemetery 7-15-2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Lassahn Funeral Home algnature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in recitate cause. Enter Underlying Examine Due to (unds a nunsequence or) sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No ၉ in 24 hours after deach... he Funeral Director: After this of maleted filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë 28d. Describe how injury occurred X Natural 5 Pending Certificat Accident Suicide Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title 29d. Date signed (Month, Day, Year, 101 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP

DHMH 17 Rev 7/2009

State Registrar

2011

HILDA BECKER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registra Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year BUYLE 2140 ELLSWORTH 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death HARFORD **Examiner** 4b. City, Town, or Location of Death UPPER CHESAPEAKE BEL AIR Social Security Number 6. Sex 1 **□** 4 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. (Month, Day, Year) Months Hours Country) 219-03-4448 92 Yrs. **Director** 18,1919 MD Mar Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Harford Harford County ~Forest Hill Maryland 1 ☐ Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 1699 Campbell Rd. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Be Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 yrs. Machinist American Can Co. Vr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Boyle Ida Kaelber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is 1699 Campbell Rd. Forest Hill, Md. 21050 Kenneth D. Boyle (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 7-14-2011 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home arre of Funeral Service Licensee 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Anemia Severe disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dispase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consumence of Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical that the death certificate be 68760 y the attending phone of the ched for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23h. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? Day Year 1 Yes 2 9 Unknown Yes 2 No 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? law requires Records, Dementic 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Depression 24a. Was an this certificate has be all director, page 2 s autopsy performed? To the Hospital or Attending Physician; The 1 🗌 Yes 2 🗌 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 IDOA within 24 hours after useru.

To the Funeral Director; After th 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Matural Natural 5 \square Pending work? 2 Accident
3 Suicide
4 Homicide 1 Tes 2 \square No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Geriflying Nurior Pranticion: To the basis of my noveledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 66641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa Kirklanc 500 UPPER CHESAPEAKE DR MO 21014 AR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

II II

1204

			For State Registrar	State of Ma	arylan	-	artment o <i>tificate o</i>			Mental Hy	giene Reg. N	2011	22185
	Physicia		1. Decedent's Name (First, Middle, L.	ast) Elizabe	eth L	ee Bak	er			2. Date of De Month	eath Pa	L. 201	3. Time of Death 1 7:12 P M
	Medic Examin		4a. Facility Name (if not institution, gir Laurel Regio	1 11	pita	./	4b. City, Town	n, or Locati	ì	7		Princ	
	Funeral Director		5. Social Security Number 6.		(In yrs. la	st birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da July	th.	9. B	irthplace (State or Foreign puntry) aryland
	ryland r-f show ied at	ctor	Usual Residence of Decedent 10a, State 10b. County			, Town or Loc	cation						10d. Inside City Limits 1 Yes 2 X No
	with the Ma s 23a or 28a ust be notif	Funeral Director	MD Prince 10e. Street and Number 14709 Bowie Roa	George d #203	Lau	rel	10f. Zip Coo					tizen of What C	
980	s after death ral", or item Examiner m		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates,	ver in U.S No	ŀ	Vas Decedent of Yes, specify C	uban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify: Wh	ite, etc.
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's (Specify only highest states) Elementary/Seconday (0-12)	Education	+)	(Give I life. D	lent's Usual Oc kind of work do O NOT use retii	ne during n red)	nost of work	ing	F	(ind of Busines:	,
Maryland 2	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	To Be (17. Father's Name (First, Middle, Last Robert Lee Jenk			OTTIC	e Hanay	18. M		ne (First, Middle, Mitche)	Maiden		
Man	2 shoul Ith and I 27 is ma trauma		19a. Informant's Name/Relationship Timothy J. Bake				,			al Route Numbe			(ip Code) MD 21043
Baltimore,	Page 1 and nent of Hea int: If item iry or other	100	20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other (Spe	Removal from State	CE	lace of Dispo emetery, cren	sition (Name of natory or other	place)		Date	20c. L	ocation - City o	
Balti	permit. Page 1 Department of Important: If i any Injury or once.		21. Signature of Funeral Service Lice	insee /	M007	73 3	Name and Ado Onalds 313 Tall	dress of Fa	neral Ave. I	Home, l Laurel,	P.A. Mary	yland 2	0707-4389
	Physician/	(C. 0)	23a. Part 1. Enter the disease, or co shock, or hear failure. List only Immediate Cause (Final disease or condition	mplications that caused one cause on each line	the death	n. Do not ente	r the mode of a In Far	ctio	as cardlac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner	JE.	resulting in death) Sequentially list conditions,	Due to (or as a	consequ	ence of): Destru	ictive	Pul	mono	ary I)ise	idse	
	ecuted and -transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Chronic	c K	idney	Dise	edse	St	age I	V		
092	cate be executed physician and s the burial-transit			. Sepsi	S	Syn	dromi	೬					
Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Lirector After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	Ideath 3	Ectopic pregr Other (specify					23d. Date of d Month	elivery Day Year
Is, P.O.	uires that the dec n signed by the a uld be detached i	by	Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the u	nderlying cause	e given in P	art I.				to the cause of death? Probably 4 Unknown
Records,	The law require: ate has been siç page 2 should k	Completed								24a, Was auto perfo 1 Yes	psy ormed?	prior to	outopsy findings available o completion of cause of es 2 XNo
of Vital	/sician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:	unt 2 □ I	ER/Outpatier		Other:	Death (Chec	<i>k only one)</i> ome 5 ☐ Resi	dance 6	S C Other (Spe	solfs)
n of	ding Physician; T th. After this certifica funeral director, p		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of injur (Month, Day	у	28b. Time of injury	28c. li	njury at vork?		28d. Describe 1			cary)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director A completed filled in by the fu	al Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Inju					NO NO	28f. Location (City or Tox			ural Route Number,
	e Hospi 24 hou e Funer	Medical	(Check 2 L Medical Exa	nysician: To the best of ominer: On the basis of ourse Practioner: To the	amination	and/or invest	igation, in my o	pinion, deat	h occurred a	t the time, date	and place	e, and due to the	e cause(s) and manner stated.
	To the within 2 To the comple	~	29b. Signature and title of certifier	20) -	7 04		ense numb				te signed (Mon	
	,		30. Name and address of person who George I, OKar				egion	1 H	ospita	730	o Vi	an Du	sen Road
	Star Registra		31. Date filed (Month, Day, Year)	32 egistra			who I					·) 171 -1	, , , , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ /5 /2011 Ida Bell-Washington 3.00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** not applicable Baltimore Manor Care Roland Park If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday **Funeral** Min. (Month, Day, Year) L/18/1928 Country) 1 🗆 M 2**X** 🗆 F Months Days Hours 83 **Director** 217-22-2773 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21216 1214 Bloomingdale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Assembler Eastern Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David White Lillian McGreer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4002 Greenspring Avenue Baltimore, MD Jeannine Cawthorne/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 7/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Owings Mill, MD Garrison Forest VA 22. Name and Address of Facility 4300 Wabash Avenue Sign ure 6 Funeral Service Licenaee March FH West Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nock, or heart failure. List only one cause on each line Interval Between Onset and Death mediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Gause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Completed by

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi ODivision of Vital Records, P.O. Box 68760 ate has been signed by the page 2 should be detached After this certificate To the Funeral Director: After this certific completed filled in by the funeral director, within 24 hours a

Baltimore, Maryland 21215-0036

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
art II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
5. Was case referred to medical	26. Place of Death (Check	only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 Other (Specify)
7. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 00069314 07/06/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prajapati Mittal

Parkalle MD 21234

28f. Location (Street and Number or Rural Route Number,

State Registrar

Be P

Certificate:

Medical

☐ Accident ☐ Suicide

Homicide

Investigation Could not be

determined

		_	State Amend Ite	m 27 State of per m	Marylan e,g917	d/Dep: ,07/13 Ce/	artment of l /2011dhb tificate of l	Health and Dea <u>th</u>	d Mental Hy	giene Reg. No.		22187
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part of the same	/ledic		4a. Facility Name (if not institution,		JR er)	,	4b. City, Town, o	r Location of De		4c. County	-	01111
				NAVAL ACAD			1	POLIS			ARUN	
Fun Dire	eral ctor		5. Social Security Number 257–47–7743	6. Sex 1 M 2 D F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days		din. March I			place (State or Foreign Wsta, GA
and	at	or	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
Maryli 28a-f	otified	Director	MD Anne A	rundel	Fe	rndale						1X☐ Yes 2☐ No
with the	ust be n	Funeral D	10e. Street and Number 34 Vista Ave				10f. Zip Code 21061			10g. Citizen of V		*
faryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show	Examiner m	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🌠 Divorced	12. Was Decede Armed Force 1 Å Yes 2 If Yes, Give Year or Date	s? □ No Unknow	1 1	Was Decedent of H f Yes, specify Cuba X Yes 2 □ No	an, Mexican, Pu		Blac	e - Americ ck, White, e H is]	etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o	the Medical	Completed		nt's Education st grade completed) 2ollege (1-4	or 5+)	I (Give	dent's Usual Occup kind of work done o O NOT use retired)	during most of u	working	16b. Kind of B		
be filed w ental Hygi	ic event,	To Be	17. Father's Name (First, Middle, L Melinda Gon	,					Name (First, Middle,		e)	
2 ₹ 5	er traumat		19a. Informant's Name/Relationsh Melinda Barric			19b. Mailir 34 Vi	ng Address (Street Sta Ave,	and Number or Fernda	Rural Route Numbe	r, City or Town, S . 061	State, Zip C	Pode)
Baltimore, permit. Page 1 and Department of Heal mportant: If item	ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate c	emetery, cren	sition (Name of natory or other place Cremator		Date -13-2011	20c. Location -	•	own, State
Baltimor permit. Page 1 Department of Important: If it	any inj once.		21. Signature of Funeral Service L	icensee					Joseph Gaw			
´ Physic	ian/	100	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each	line.	h. Do not ente		ig, such as card				Approximate Interval Between Onset and Death
Exam	iner		resulting in death) Sequentially list conditions,		as a consequ		3.110 HADAN					
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760 cate be executed physician and	e burial-tı	edical E	resulting in death) Last	Due to (or	as a consequ	uence of):						
6876 ertificat iding ph	e as th	/Mec	IF FEMALE:	00-16								
Box death c	ched for us	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta ntattime of d	aldeath 3	Ectopic pregnand Other (specify)	су			te of delive onth	ery Day Year
IS, P.O. uires that the n signed by t	uld be deta		Part II. Other significant conditio	ns contributing to dea	th but not res	ulting in the u	nderlying cause gi	ven in Part I.				ne cause of death?
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Of VI Physi r this c	eral dir	<u>ن</u> کو	1 🔀 Yes 2 □ No 27. Manner of Death	1 Unp	injury	ER/Outpatier 28b. Time of		4 ☐ Nursin	g Home 5 Resid	dence 6X Other		WORK
on C ending eath. or: Afte	he fune	ficat	1 Natural 5 X Péndin 2 Accident Investig 3 X Suicide 6 Could i	gation MAY 19	Day, Year) 9 2011	injury UNK	work	Yes 2 No		T WOUND		HE HEAD
DIVISION OF pspital or Attending Ph hours after death. Ineral Director: After th	in by t	Certificate:	3 X Suicide 6 ☐ Could i 4 ☐ Homicide determi	inod 28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory, office		City or Tou	IN E		Route Number, ACADEMY
* Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	eted filled	Medical	(Check 2 Medical E	Physician: To the bes xaminer: On the basis Nurse Practioner: To	of examination	ledge, death on and/or invest	occured at the time	on, death occurr	red at the time, date a	IS MD use(s) and mannand and place, and due	er as state	d. use(s) and manner stated.
To the within To the	сош		only one) 3 L Certifying 29b. Signature and title of certifier	1	Life Deat Of ITI	, Allowiedge, (29c. Licens		prace, and due to th	29d. Date signed	d (Month, I	Day, Year)
			Step	ma Kirt	mm	mp	D340		OD CITIC STATE	JUNE		
3			30. Name and address of person v STEPHEN L. ROB	·	,	23a) (Type, F USN	,	ARMED FOR	ORCES MED LE MD 20	ICAL EXA 850	AMINE.	K
Reg	Stat gistra	e	31. Date filed (Month, Day, Year)			. pa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 20:00 PM 2011 Taylor Bond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Rosedale HOSDITA Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** fMonth, Day, \ Year 2011 1 □ M 2 🛛 F 15ⁱⁿ2 Maryland Director INFANT Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA Completed by Funeral 5694 Leiden Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give black Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) TNFANT Elementary/Seconday (0-12) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Danielle Byrd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5694 Leiden Rd; Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type, Print) Danielle Byrd - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) in State nera Se vi licensee anviel Nav lor 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Premature delivery at 22 weeks gestation Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to for as a consequence of: rany, reading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Euneral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed 1 Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 XNo မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53355 5 7 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elgin 9000 Franklin one Drive Baltimore MD Kathryn M.D

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ANIEL, G. BOWERMAN 0521AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD OLUM BIA HOWARD COUNTY GENERAL HOSPITA If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🔀 M 2 🗆 F Months NOV. 13 Year 928 Mary land 212-30-0369 82 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Baltimore 1 Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? Funeral 21043 USA 524 Oella Avenue hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Credit Card should be filed with and Mental Hygien 7 is marked other tf Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Alice Moore Biavs Shannon Ignatius Bowerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 524 Oella Avenue; Ellicott City, MD 21043 permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Elizabeth Bowerman Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7/13/2011 Balto-Wash.Crematory Laurel, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catons Ville, Inc. 21. Signature of Funeral Service Licenses Masso 1630 Edmondson Avenue; Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DullmonA Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner (15PD) Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury HYDUTENSION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 NA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 124 hours after death. cate has t autopsy perform death? 1 ☐ Yes 2 ☒ No 2 No certificate 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Npatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending in 24 hours atter continue the Funeral Director. Af 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

within 2 To the I

COUNTY State Registrar

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSPITAL.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number Dows

CULUM BIA

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21044

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11-05097 Herbert Dews

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene 2011 22190

		1- For State amend Registrar	#19a&b Per 1	ertificate (of Death			Reg.	No.	
Physicia	ın/	Decedent's Name (First, Middle,Las					Mon		ay Year	3. Time of Death 1458 hrs
Medical Exami		Herbert Roosevel			4b. City, Town, o	r Location of		8, 2011	4c. County of	
,		4a. Facility Name (if not institution, give Johns Hopkins Bayview M	edical Center		Baltimore					
Funeral Director		Social Security Number 6. Security Number		. last birthday)	If Under 1 Yea		Min.			Birthplace (State or Foreign
Director			M 2 F 77	Y	rs.		Jur	ne 14	1934	Country Virginia
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	ation					10d. Inside City Limits
. t		Maryland Harford	λh.	ingdon						1 Yes 2 No
Maryland 28a-f show d at once.	용	10e. Street and Number	i Ao.	Linguon	10f. Zip Code			10g.	Citizen of Wha	at Country?
ith the Maryland 23a or 28a-f sho notified at once	Director	3608 Philadelphi	a Road		21009			Ţ	JSA	
ms 23	Fra	11. Marital Status	12. Was Decedent Ever in		Vas Decedent of Hi Yes, specify Cuba				14. Race - White,	- American Indian, Black,
hours after death with the Maryland 'natural', or items 23a or 28a-f sh Examiner must be notified at once	Funeral	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 No	"			Fuerto Ricari, e	510.)		
s after	à	3 X Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	16a Deced	Yes 2 X No		ind of work don	ne 16		Black siness/Industry
136 thin 72 hours a then "natura edical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		most of working life			1	op. rand of Edd	and our radiotry
0036 within 7: jene.	ğ		2	Mast	er Sergea	ant	1, "		U.S. G	Sovernment
21215-0036 wild be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)				11111111111	s Name (First, M			
2121 uld be fil Mental I marked	B	Golie Ralph Dews					e (nmn)			
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프 면본 문 중	ı	20a. Method of Disposition	206		osition (Name of ce		Date			City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3		-	n Nat'l.	Cem.	(unk)	1,	Arlinat	on, Virginia
altir mit. P partme	1	4 Donation 5 Other Specify: 21. Signal of Funer of Funer of Pervice Licen			Name and Addres					
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Physician		23a, Part I. Enter the disease, or comp failure. List only one cause on ea		th. Do not enter	r the mode of dying	ı, such as ca	ardiac or respira	atory arrest	, shock, or hea	Between Onset and
√Medical' Examiner			Multiple Injuries							Death
		b	Due to (or as a consequence	or):						
	힏	if any, leading to immediate	Due to (or as a consequence	of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):						
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760, cate be executed physician and the burial - transi	Medical	UNPENDED	AMENDED							
Z 2 2 4		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		Fetal death 3	Ectopic	pregnancy		23d. Date of o Month	delivery Day Year
ox 687 eath certifu attending for use as t	E.	past 12 months?	4 Pregnant at time of		Other (Specify)		programo			
Box ie death c the atten	Physician	1 Yes 2 No 9 Unknown	9 Olikilowii		•	_				
P.O. es that the igned by	by P	Part II. Other significant conditions	contributing to death but not	resulting in the	e underlying cause	given in Par	rt I. 23			bute to the cause of death? Probably 4 Unknown
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of Vital Records, og Physician: The law require ther this certificate has been si meral director, page 2 should t	Completed							autopsy performe	pı	nor to completion of cause of eath?
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Vital Reo ysicien: The his certificate director, page	Be	25. Was case referred to medical examiner?	lospital:	7		Tou.	Check only one			
Physic	의	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o		ury at Work?	Nursing Home		v injury occurre	
	Certification:	1 Natural 5 Pending	FOUND: Day, Year)	FOUND:	· · ·	Yes 2	Driver		to collision	
Division tal or Attendii 11 Director: /	lical	2 Accident Investigation 3 Suicide 6 Could not	28e Place of Injury - At	1355 hrs home, farm, str	reet, factory, office	building, etc				er or Rural Route Number, City
Div ospital o hours afi uneral D	in in	4 Homicide determined		ad / Highwa	ay		Route	Town, Stat 40 & Jone	es Avenue, C	hase, MD
To the Hosy within 24 hc To the Fun. completely in	Medical C		an: To the best of my knowle On the basis of examination							
To with	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		2	9d. Date signe	ed (Month, Day, Year)
		Carol HE	llda		0.0	.M.E.			July 9, 2011	1
81,	ŀ	30. Name and address of person who			altimone Ct	Dolling -	MD 242	22		
		·	nt Medical Examiner 32. Registrar's Signa		animore street	, baitimo		۷.		
St Regist		31. Date filed (Month, Day, Year)	d. A.	ticle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JULY Physician/ GEORGE FRANCIS DIETZ, JR. 2011 4:15AM M Medical 4a. Facility Name (if not institution, give street and number) County of Death
BALTIMORE 4b. City, Town, or Location of Death **Examiner** TOWSON GILCHRIST CENTER Birthplace (State or Foreign Country) . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) (Month, Day, **X** X M 2 □ F Days 215~30~5555 78 Aua **Director** Maryland Usual Residence of Decedent shov 10a. State 10b. County 10d Inside City Limits 10c. City, Town or Location Examiner must be notified at with the Maryland Director 28a-f Worcester Newark 1 Yes X No Maryland 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 7609 Mulberry Rd. 21841 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? ↑ A Yes 2 □ No If Yes, Givekorean Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 X Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 yrs. 4 yrs. Letter Carrier U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, George Francis Dietz, Anastasia Gertrude Nord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Dietz (Son) 7609 Mulberry Rd. Newark, Md. 21841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-13-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Signature of Funeral Service Licensee 7. 7401 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -19 disease or condition resulting in death) montas Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Pregnant at time of death 1 Yes 2 L g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ပ 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending February 21, 2011 2 No Fell our OF Bed 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Home occan cin mo N. Philadelphia Ave Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 301 5 of death (Ilem 23a) (Type, Print) 32. Registrar State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g917 7-13-11 yt State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10^{Day} Physician/ 3:20 July 20 โ Ам Robert Peter Dema Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Hours Min 05/297194 1 XM 2 □ F Months 062-34-4625 70 Director NY Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD Baltimore Nottingham ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 4138 Brookfield Avenue 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 3:20 permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Tractor Trailer Operator Jones Motors Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Peter Dema Helen Pasco 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4138 Brookfield Ave Nottingham, MD 21236 Robert Dema Jr.-Son 10, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 Cremation 3 ☐ Removal from State on 5 ☐ Other (Specify) Ardent Crematory 7.11.2011 Hanover, MD 4 Donation Other (Specify) 21. Si f Funeral John L. Williams Funeral Directors, P.A. 4517 Park Hots Ave Baltimore, MD 21215 ure Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ LIVER DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam and burial-tran Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ROBERT DEMA in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed eral Director: After this certificate filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 👿 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita Other: 1 Yes 2 X No မြ 1 🗋 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work 1 X Natural 5 Pending 1 🗌 Yes after death. 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed Month, Day, Year) 201 son who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARLE) JULY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1206 Schucks Road Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 4. Aug • 18, A Funeral Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F West Virginia Director 236-52-1304 76 Aug. 1934 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No Bel Air Maryland Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a c Funeral 1206 Schucks Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Automotive Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Eldie Carl Farley Georgia Myrtle Pack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 sl of Health a Marlene Farley / Wife 1206 Schucks Road, Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Highview Memorial Gdn 7-9-11 Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Contivaco 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eu/s disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner orgestino squentially liet conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): 51 sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DQA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of cortifier

Bahrani

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602 S.

29c. License number 84

Atwood Rd., Suite 200, Bel Air, MD 21014

29d. Date signer

(Month Day, Year) 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

		-	1 - State of M State of M Registrar	aryland /		nent of He cate of De		ientai Hyg	Reg. N 2011	22194
۱	Physicia		1. Decedent's Name (First, Middle, Last) JOHN EDWARD	FAI	RLE	Y		2. Date of Dea Month		3. Time of Death 12:21 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number) Laurel Regional Hosp	oital	4b.	. City, Town, or Lo	ocation of Death	, , , ,	4c. County of Deat	
	Funeral Director			e (In yrs. last bir		Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Dec 21	9. Bir	thplace (State or Foreign untry) th Carolina
		or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Locatio	n				10d. Inside City Limits
	Maryla 28a-f s otified	Funeral Director	MD Prince George's	Laur	el					1 ☐ Yes 2XX No
:	th the	al D	10e. Street and Number		1	Of. Zip Code			10g. Citizen of What Co	puntry?
	ems 2	nne	10403 Balsamwood Drive 11. Mantal Status 12. Was Decedent		13. Was	20708 Decedent of Hispa , specify Cuban,	anic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ame	rican Indian,
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland do Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "matic event, the Medical Examiner must be notified at.	Completed by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes, Give Year or Dates.	No 1967- 1968	If Yes	, specify Cuban, l Yes 2 💢 No		Rican, etc.)	Black, White Specify: Af: Amer:	
15-	72 hou n "nati ledica	nplet	15. Decedent's Education (Specify only highest grade completed)	16a	(Give kind	s Usual Occupation of work done duri		ing	16b. Kind of Business Montgomery	Industry
212	within glene. er tha , the N		Elementary/Seconday (0-12) College (1-4 or 9 12th 4		Counse	•			Detention (
פ	e filed ttal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			1			Maiden Surname)	
	12 should be file alth and Mental H 27 is marked or r traumatic eve		James Luther Fairley 19a. Informant's Name/Relationship (Type, Print)	10	h Mailing Ac	idrops (Street and		ase Stub	City or Town, State, Zi	n Code)
ĕ Z	and 2 shu Health an tem 27 is other trau		William H. Fairley/Brother		-	irsalli		Hope Mil		348
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemete	-	n (Name of ry or other place) el Crem.	1	Date 3/2011	20c. Location - City or Odenton,	,
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	M00770		me and Address of	of Facility Do	naldson	Funeral Horel, MD 20	me, P.A. 707
			23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line		not enter the	mode of dying,	such as cardiac	or respiratory arr	est,	Approximate Interval Between
	nysician/ Medical		regulting in death)	SIS a consequence	of):					Onset and Death
مسب	Examiner	يا	Sequentially list conditions, b.	,						
3	uted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease on highly that initiated events C.	a consequence		-				
	icate be executed physician and s the burial-transit	edical E	resulting in death) Last Due to (or as	a consequence	e of):					
8760	incate ig phys as the		IF FEMALE:							
Box 68	to the hospital or Attending Prysican: The law requires that the been centure within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arending prompleted filled in by the funeral director, page 2 should be detached firruse as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fetal deat		topic pregnancy her (specify)			23d. Date of de Month	livery Day Year
О	rnar m ned by e detac	by Ph	Part II. Other significant conditions contributing to death b	out not resulting	in the under	lying cause given	in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds,	quires en sigi buld be	ted k	<u> </u>	-				1 🗆 '	∕es 2 □ No 3 □ P	robably 4 Unknown
Records,	ne law re Ite has be iage 2 shi	Completed	<u> </u>					24a. Was a autop perfo 1 Yes	sy prior to death?	topsy findings available completion of cause of
ta .	cian: I ertifica ector, p	Be C	25. Was case referred to medical examiner?			Louis	e of Death (Chec		2.04(0)	
	rnysi rthis o ral dire	<u>ان</u>	1 Yes 2 No 1 Inpati 27. Manner of Death 28a. Date of inju	ient 2 ER/O	Outpatient 3 Time of	DOA Other:			ence 6 Other (Spec	cify)
ouo	tending leath. tor: Afte the fune	Certificate:	1 Natural 5 Pending (Month, Da 2 Accident Investigation 3 Suicide 6 Could not be	y, Year)		work? √l 1 □ Ye	s 2 🗆 No			
Division of Vital	urs after or al birect ral Direct led in by		4 Homicide determined 28e. Place of Inj building, et	c. (Specify)			9	City or Tow		
:	e nosp n 24 ho e Fune pleted fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of 6 3 Certifying Nurse Practioner: To the	examination and/	or investigati	on, in my opinion,	death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.
_ ;	Within Comp		29b. Signature and title of certifier			29c. License n			29d. Date signed (Mont	A
			30. Name and address of person who completed cause of c	leath (Item 22a)	(Type Print)	D55		300 \/4:-	July 1. Dusen R	0, 2011
١,			Abdul Munim, MD Lai	urel Re	giona	Hospita	al L	aurel,	MD	20707
	Stat Registra		31. Date filed (Month, Day, Year).	ar's Signature	2.					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mont **Physician** Zoll amini VIary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 5. Social Security Number **Funeral** 217-24-5462 Maryland 1 M 2 Z F 81 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 ⊈Yes 2 ☐ No Director Md. Baltimore City 28a-f 10f, Zip-Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 213 South Exter Street 21202 U.S.A. by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates Specify White 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Elementary/Secondary (0-12) than College (1-4 or 5+) Hygiene. Teachers Aid City Schools permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John DeMartino Angelina DelPizzo ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Flamini / Daughter 213 South Exeter Street Baltimore, Md. 21202 July Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 11,2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License Dundalk Avenue Baltimore, Md. 21222 1201 who or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a construence of //Medical Examiner Ca Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or us a consequence of) requires that the death certificate be executed IVCV an burial-trar that initiated events and Due to (or as a consequence of): resulting in death) Last Box 68760, nding physician Physician/Medical as the b nse IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day atter in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the att 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>م</u> should be 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has performe 1 Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 XYes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient 2 completely filled in by the funeral 28c. Injury at Work? 27. Magner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined

Hospital or Attending P. 24 hours after death.
Funeral Director: After the 24 hours a

> State Registrar

Medical

29a. Certifier (check only

one)

29b. Signature and title of certifier

30. Name and address of person who complet

and manner stated.

d cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 2011 Gorham Janet 3:00a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gracious Living Assisted Living Reisterstown 5. Social Security Number 8. Date of Birth (Month, Day,) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Months Year) 53 218-66-1402 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director or 28a-f s notified MD Baltimore NA 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 21 Tomber Court 21207 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: Black "natural", Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life, DO NOT use retired) Morning Star than Elementary/Seconday (0-12) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the N College (1-4 or 5+) 12th grade Baptist Church 6yrs Daycare Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Daniel Cherry Jr. Henrietta Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia V. Jones-Sister Tomber Court, Baltimore, Md 21207 other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site Baltimore, Md 7/12/2011 Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av al Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line AMOL Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** BREAS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the s should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy page 2 Yes 1 🗌 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' Hospital 2 No Other: 121220 မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence . Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. After 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No M Investigation Director: completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 3 only one 29b. Signatur and title of certifie icense numbe 29d. Date signed

State

30. Name and address of

person who completed cause of death

trar's Signature

2011

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Month Milda 5:36 A M Gaither 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore 7444 Ricksway Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year, Min 1 □ M 2 □ F Director Maryland 212-26-7576 Dec 4, 1930 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 ☐ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 7444 Ricksway Road 21208 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 Yes 2 No 1 Tes 2 X No Specify: If Yes, Give Specify. Black 3 Widowed 4 Divorced h and Mental Hygiene.

It is marked other than "natural" traumatic event, the Medical Ex Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **MVA** Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gennie Moore Lindsey Moore of Health and Mer of Health and Mer If item 27 is mark or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Hillview Road Baltimore, Maryland 21223 Angela Gaither 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or ot once. cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 07/13/11 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Luna cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Inijury that initiated events Due to (or as a consequence of): tran and Due to (or as a consequence of) resulting in death) Last as the burial physician Physician/Medical requires that the death certificate be P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law autonsy this certificate has performed; death? 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 nsky aparlanin 00057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD

DHMH 17 Rev 7/2009

State Registrar

2835 Smin Av

5-703

N. J. Rijapaksem o

32. Registrar's Sig

		-	1 - State of Maryland / De State of Maryland / De Registrar	partment of Health ertificate of Death	า and Ment า	al Hygiei Reg.	ne 2011	22198
	Physicia		1. Decedent's Name (First, Middle, Last) Pauline June Gray			ate of Death	Day 2011 Year	3. Time of Death 11:05 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number) Jacobs Well Assisted Living	4b. City, Town, or Location Bel Air	on of Death		4c. County of Death Harford	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 1 M 2 🔀 F 95 Yrs.	Months Days Hours	der 24 Hrs. 8. Da s Min. (M	ate of Birth	9. Birti 1915 Per	nplace (State or Foreign Intry) Insylvania
pue		or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
Maryland	r 28a-f	Director	Maryland Harford Bel Air	10f. Zip Code		100	, Citizen of What Co	1 ♣ Yes 2 □ No
with #	s 23a c ust be	Funeral	312 Ewing Street	21014		ľ	JSA	
36 after death	popularity and the part and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☒ No Specif	can, Puerto Rican,	es or No- , etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
2-00	"natura	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during mo	ost of working	16	b. Kind of Business I	
2121 Within 2	jiene. er than the Me		Elementary/Seconday (0-12) College (1-4 or 5+)	. DO NOT use retired) counting Clerk	ζ.	r	Telecommur	nications
pue	ed othe	To Be	17. Father's Name (First, Middle, Last)		other's Name (First			
aryla	ind Mer s mark umatic		William Henry Beal 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Num	ith Cathe nber or Rural Rout			Code)
e, X	Health a			Box 210, Fal	llston, N		17 c. Location - City or	Town State
mor	int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, c	rematory or other place) Cemetery	7-13-1		•	, Maryland
Baltimore, Maryland 21215-0036	Departn Importa any inju		21. Signatury Funeral Service Licensee	22. Name and Address of Fact McComas Funer 50 W. Broadwa	ral Home	P.A.	21014	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such a	as cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	'IRATORY	FAILU	RE	-	Onset and Boats
	xaminer	er	Sequentially list conditions, b. Due to for as a non-sequence of					
outed	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c					
60 ate be exec	physician and is the burial-transit	edical E	resulting in death) Last Due to (or as a consequence of): d.					
P.O. Box 6876 that the death certificate	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	cian/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □ Th	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del	ivery Day Year
D. B	by the a	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown					
ds, P.(been signed by the s	ted by	Part II. Other significant conditions contributing to death but not resulting in the HYPERTENSION	e underlying cause given in Pa	art i. 2		co use contribute to	obably 4 Unknown
Division of Vital Records, all or Attending Physician: The law requires	cate has be page 2 sh	Completed by Physician/M	DEMENTIA			24a. Was an autopsy performed 1 Yes 2	prior to death?	copsy findings available completion of cause of
Vital	s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Other	Death (Check only		e 6 XX Other (Spec	Assisted
on of	within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page.	Certificate: 7	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		_	Describe how i	injury occurred	"Living
Divisi	s after de I Directo d in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		ocation (Stree City or Town, S	t and Number or Rui tate)	al Route Number,
) , and Hospit	n 24 hour ne Funera pleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the control of the best of my knowledge, deal of the control of the best of my knowledge. 2 Medical Examiner: On the best of my knowledge.	vestigation, in my opinion, death	h occurred at the tir	me, date and p	lace, and due to the o	ause(s) and manner stated.
	vithi To th		29b. Signature and title of certifier WHShyaular MA	29c. License number	er 7		Date signed (Month	, Day, Year) 201(
	()		30. Name and address of person was completed cause of death (Item 23a) (Typ	e, Print) ORTH AVE	BEL	ATR	MD 21	014
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Olovi et VL	(0000		- 2 41	×1,7 *

			1- For Amend Item 23a, 26, 28a, c,e,f per dr., g917, 07/13/2011 dhb Reg. No. 20 2	2199
	Physicia	n/	Month Day Year	Time of Death
	Medic	al	haissa, Galitzin June 23 2011 10	0:15 pm
	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Country) 1 Months Days Hours Min. (Month, Day, Year) 1 0 / 28 / 1 9 2 3	State or Foreign Estonia
	und show at	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In	side City Limits
	ne Maryla or 28a-f s notified	Funeral Director	MD Baltimore 106. Street and Number 106. Zip Code 10g. Citizen of What Country?	Yes 2 No
	s 23a o	neral	5013 Roland Avenue 21211 USA	
900	e filed within 72 hours after death with the Maryland tal Hygiene. All Hygiene. And other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Seack, White, etc.	·
21215-0036	thin 72 hou ane. than "nat u the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant YWCA	l a
	led within I Hygiene. other thai rent, the N	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
ylan	ild be fil Mental narked atic eve	욘		
, Mar	1 and 2 should be fili of Health and Mental item 27 is marked of other traumatic eve		19a. Informant's Name/Relationship (Type, Print) Michel Galitzin / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3239 Chestnut Ave., Baltimore, MD 2	1211
Baltimore, Maryland	0 = =		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 5 Final Journey crem. 6/27/2011 Woodbine, MD	state
Balt	permit. Page Department Important: any injury conce.		21. Signature of Funeral Service Licepsee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 2120	า 3
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a specific control of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the c	roximate val Between
	h sician/ Medical	i	Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of):	et and Death
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	sit sit	Examine	if any hading to immediate cause. Enter Underlying Cause, Disease or iinjury A Constant Con	
	ate be executed ohysician and the burial-transit	Еха	Cause (Disease or Injury that initiated events resulting in death) Last C. MCTOSTOTIC JUNG CONCET Due to (or as a consequence of):	
09	tte be e hysicia he bur	dical	d	
687	eath certificat attending pt I for use as th	/Me	IF FEMALE: 23b. Was decedent account. 23c. If yes, outcome of pregnancy	
. Box 687	g 5 9	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 1 Live Birth 2 Fetal death 5 Other (specify)	Year
P.O.	es that the signed by be detact			
rds	v requires s been sig should b	eted	1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy fin	
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the director, page 2 should be detach	Completed by	autopsy performed? 1 Yes 2 No 1 Yes 2	ion of cause of
tal	cian; '	Be	25. Was case referred to medical examiner?	
ζ	Physical this caral dir	e: To	1 Ma Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
ono	ending sath. or: After he funer	ficat	1 Matural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No	
ivisi	l or Attenc after deatl Director: I in by the	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	e Number,
Δ	Hospital 24 hours Funeral ted filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).	
	To the To the To the Comple	Š	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, You	'ear)
			Markell Maure BES 000 6/23/201	(
	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1
	Stat	e	31 Data filed (Month Day Year) 29 Pagiston's Signature	215
	Registra		JUL 1 2 2011 James J. James	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 18:59 M 08 170 Juin 2011 <u>lason</u> /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 5, 2011 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ÅM 2□F Days 3 Maryland 213-91-7771 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Md. Havre de Grace 10g. Citizen of What Country? 10e, Street and Number 10f. Zip-Code 21078-4225 U.S.A. 116 Hunter Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ∏ Yes 2 TXNo If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental Hitant: If item 27 is marked out Be Elizabeth Ann Sallese E. Donald Goff, III 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl & Beverly Sallese Grandparents 2902 Squire Court Baldwin, Maryland 2<u>1013</u> permit. Pages 1 and Department of Health Important: If Item 2: any injury or other to other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July Pate 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 12, 2011Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral home, P.A. 21. Signature of Funeral Service Licenses who 1201 Dundalk Avenue Baltimore, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ardiac tailure disease or condition resulting in death) /Medical Due to (or as a conse mence of) Examiner Etralogy of Europe (or or a gentle or): Sequentially list conditions, if a y loading to in reclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami collateral vesse aortopulmonary attending physician and d for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No P.0. 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 2 No 3 Probably 4 Unknown 1 Tes Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 has 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After it 5 Pending investigation injury 1 Yes 2 No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000 08 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/200

State

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Yang 31. Date filed (Month, Day, Year)

JUL 1 3 2011

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yea 5:55 AM Hill Lee Bertha 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1034 N. Arlington Baltimore Baltimore 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Hours Min (Month, Day, Year) **Director** 215-28-6015 78 Usual Residence of Decedent show or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director Baltimore 1 Yes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be. Funeral 1034 North Arlington Ave 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Waitress 10th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) \$adie Brooks John Spicer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212171034 North Arlington Ave, Baltimore, Jean Monroe-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ☐ Donation 5 ☐ Other (Specify) Zion 7/14/2011 Baltimore, Md Mt. 2 . Signatury of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 300 Wabash Baltimore, Md Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of gang/ioniz disease or condition resulting in death) 2vrs Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consumience of the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hyperlipidemia, DJD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 M No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year,

Holden

1 3 2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Easten

arks

R162291

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#15perFH, G917, 13 F2011, wS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22202 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:45 AM Month Edward Earl Henry 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SAINT BALTIMORE Agnes Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
1 21 39 Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2 □ F 244-56-0926 **Director** 72 Yrs NC Usual Residence of Decedent ms 23a or 28a-f shov must be notified at of and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Funeral 905 Stamford Road USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' Black, White, etc. þ 1 Never Married 2 🔀 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Directrate of Elementary/Seconday (0-12) College (1-4 or 5+) GED 12th Grade NA Driver Logistics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Randolph Henry Minnie Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
905 Stamford Road Baltimore, MD 21229 Emily Henry - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ott once. Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 7/14/2011 Owings Mills, Md Garrison Forest # Funeral Service Licensee 21. Si matur 22. Name and Address of Facility 4300 Wabash Avenue March F/H West, Inc. Baltimore, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSclerotic Cardioviscular Disease disease or condition UNKNOWN Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a nonsequence of if any leading cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE Renal disease Records, 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes of Wital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 410 Other: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury the Hospital or Attending 1 Natural 2 Accident work? 1 Yes 2 No 5 Pending Division Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: It the could finely investigation and the time date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) c- May D0058141 July 7,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 South Caton AVE BALTIMORE, Md. 21279 Williams State JUL 1 3 2011 Registrar

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			For State Registrar		State c	of Ma	ryland		irtmen tificate				1ental Hy				222	03
	Physicia	n/	1. Decedent's Name (First, Midd	le, Las	1.1	· (st						-	Date of De Month	ath Da	ay	Year	3. Time of De	eath
	Medic Examin		4a. Facility Name (if not institution		//				4b. City,	Town, or	Location	n of Death	Jul	40	2 c	of Death	1 10 1 1	141
			Howard Count 5. Social Security Number	7 Ge			ital	hirthday	If Under	olum		er 24 Hrs.	8. Date of Bir	*-	How	vard	olana (Ctata au F	To and form
ı	Funeral Director		215-18-0227		м 2 ХХ ғ	7. Age	89	Yrs.	Months	Days	Hours		(Month, Da Nov. 7	y, Year)	921	Cour	olace (State or F try) yland	oreign
	ind show at	or	Usual Residence of Decedent 10a. State 10b. Count	у		T	10c. City, T	own or Loc	ation								0d. Inside City	Limits
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36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorce		Armed Fo 1 Yes If Yes, Giv	2 X X N	0		res, spec	_			Rican, etc.)		Blace Specify:	ck, White, Wh	_{ite}	
2-00	hours "natura dical E	plete	15. Decec (Specify only hig	ent's Ec	Year or Da lucation de completed		I.	16a. Deced				ost of worki	na	16b. l	Kind of B	usiness In	dustry	П
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, Ma	id 2 sh ealth an n 27 is er trau		Bonny Marcel			ter			-			Road ,	l Route Numbe Laur∈			20723	Jodej	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 ☐ Crematio			State	cem	e of Dispos etery, crem	atory or o	ther place			Date			_	own, State	
altin	permit. Page Department Important: It any injury or once.		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service				Ft.					7/14, ility Dona	/2011 aldson			ood, Home		
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Ŋ	Physician/		23a. Part 1 Enter the disease, shook, o heart failure. Lis Immediate cause (Final	only or	lications that one a				r the mode	e of dying), such a	is cardiac o	r respiratory ar	rest,			Approximate Interval Betwe Onset and Dea	
المسهد	Medical Examiner		disease or condition resulting in death)	•	a. Due to (consequen		-							_		
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	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or imjury that initiated events	١	c											- 4		
0	rate be executed physician and the buriat-transit	edical E	resulting in death) Last	L	Due to (or as a o	consequen	ce ot):										
876	tificate ng phy	Medi	IF FEMALE:	$\overline{}$	u									-				
9 x o	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1		Birth 2	pregnancy Fetal de ime of deal	eath 3 🗌	Ectopic p		У			1		te of deliv	ery Day Yea	ar
о. В	it the de I by the stached	Physi	9 🗆 Unknown		9 Unkr						i- D		1					
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	by	Part II. Other significant condi	/W		-	(yre	-	nderlying o	ause give	en in Pai	rt I.					ne cause of deat	
cord	has beer ye 2 shou	Completed											24a. Was auto		24b. \	Were auto	psy findings ava	uilable se of
Re	sician: The la certificate h irector, page		25. Was case referred to medica								4.5		perfo 1 ☐ Yes	ormed?	lo c	death?	2 1 No	
Vita	lysicial lis certi directo	To Be	examiner? 1 Yes 2 No	- 5	Hospital:	Inpatien	t 2 🗆 ER	/Outpatien	t 3 🗆 DO	Othou	p-	eath (Check	only one) me 5 \square Resi	dence (6 🗌 Othe	er (Specify)	
n of	ding Pł h. After tł funeral		27. Manner of Death 1 Natural 5 Pend			of injury th, Day,	Year) 28	b. Time of injury	M 2	Bc. Injury work?		_	28d. Describe I	now inju	ry occurre	ed		
/isio	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Certificate:	3 🔲 Suicide 6 🔲 Coul	tigation d not be mined	28e. Place	of Injury	- At home (Specify)	, farm, stre			165 21	-	28f. Location (City or Tov			er or Rura	Route Number,	
ă	ppital o ours aft eral Di filled in		29a. Certifier 1 Certifyin	n Phys	4			ne death o	ccured at	the time	date and	d place, and	d due to the ca			ar ac etate		
	To the Hos within 24 h To the Fur completed	Medical	(Check 2 Medical only one) 3 Certifyir	Examir g Nurs	ner: On the bas	is of exa	mination an	d/or invest	gation, in r	ny opinior	n, death	occurred at	the time, date a	and place	e, and due	e to the ca	use(s) and manne	er stated.
	With Volume		29b. Signature and title of certifi	er	3125	1	M.	D		License Do à				29d. Da	ate signed	d (Month,) عنا	Day, Year)	
			30. Name and address of person	4	_		th (Item 23	a) (Type, P	rint)					-	,,,,			
	Stat	e	31. Date filed (Month, Day, Year)	AT	5755 32. B	-	dar L s Signature		0.00	umbia	a, M	ID 21	.044					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 22204 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ J_{uly}^{Month} 12, 2011 Denise Renee Hamer 10:10aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Min (Month, Day, Year) 9-29-1964 1 M 2 X F Months Director 215-90-6929 46 Yrs Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Rosedale 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 8000 Camhill Drive 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. White Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Postal Service Clerk 12±h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e Jacob Goldstein Doris Roemer 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George M. Hamer TII 8000 Camhill Dr. Baltimore. Marvland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State West Arundel Crem 7/16/2011 Odenton, Marvland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Aneral Se 22. Name and Address of Facility Joseph N. Zannino Jr. FH timore.MD 21224 263 S. Conkling St. Baltimore.MD 23a. Part 1. Enter the disease shock, or heart failure. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Findisease or condit Physician/ netristatic bowel cancer small mouth Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Dus to for as a nonsequence on cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir -transit and resulting in death) Last Due to (or as a consequence of): burial attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be-frin 24 hours after death. Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Year Pregnant at time of death Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rheimator & authority 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a Medical 29a. Certifier ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 7/2009

State

only one

Signature and title of certifie

Partel

MUD

N Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

1200 7063L

Sufe 4105

Baltimere, NO 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 25 per phy 9917 7-26-11 sm State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician John Timothy Hubbard 6:57A July 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Baltimore-Washington Med. Ctr Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/19/1959 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. MD. 217-82-6438 1**⋈** M 2□ F 51 Director Usual Residence of Decedent Maryland 10d. Inside City Limits show. 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mydical Examination until be motified at Glen Burnie MD Anne Arundel 1 TYes & No Director 10f. Zip Code 21060 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or USÁ 7575 E. Howard Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 ☑ No Specify. If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Restaurant Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gibson William Jeanne Hubbard ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1029 St. Albans Rd., Baltimore, MD 21239 Shirley J. Mancini/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/8/2011 Final Journey Crem. Woodbine, MD 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 ans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of previous tersite and CONSCIONCE **Physician** disease or condition resulting in death) /Medical cocaine abuse Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) CENTRICATION APPROVED BY WEDICAL EXAMINES. law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \(\subseteq\) Live birth 2 \(\subseteq\) Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably ate has been s page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury 1 🔲 Natural 5 Pending UNKNOWN UNK NOWN death. 1 ☐ Yes 2 YNo investigation 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide UNKNOWN Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/6/2011 30. Name and address of pern who completed cause of death (Item 23a) (Type, Print) D. Darah Dire Ch. L. MB 21619 2107 GN S 31. Date filed (Month, Day, 32. Registrar's Signature Year) State JUL 1 3 2011 Barke Registrar

Donell Henderson 11-05044 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 22206 1- For State Certificate of Death Registrar Physician/ ent's Name (First, Middle,Last 2. Date of Death **Medical Examiner** Month Day July 6, 2011 1600 hrs ne (if not institution, give stre 4c. County of Death 6700 Block of Pulaski Highway **Baltimore** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days 215 -86-1265 Usual Residence of Decedent Foreign Country) 10a State 10c. City, Town or Location 10d. Inside City Limits narked other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at once. 1 No Director and Numbe 10g. Citizen of What Country Funeral 11 Marital Status 12. Was Deceder Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of
Department of Health and Mental Hygiene.
Important: Witem 27 is marked other than "natural", on 3 Widowed 4 Divorced Give Yeer 1 Yes 2 No specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Busine Elementary/Secondary (0-12) College (1-4 or 5+) 19b. Mailing Address SOM 20b. Place of Disposition (Name of cemetery 2 Cremation 3 Removal from State 4 Donation 5 Other Specify STRENMO **Physician** Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line /Medical Between Onset and Immediate Cause (Final disease e Narcotic Intoxication Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as e consequence of): cause. Enter Underlying Cause (Disease or injury that Immated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g917 7-18-11 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnency 2 Fetal death past 12 months? Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Dey,Yeer) 28b. Time of Injury 28c. Injury et Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 X No Unknown fd 7-6-11 fd 13:08 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6700 Blk. Pulaski Hwy. Baltimore, Md. Suicide Could not be (Specify) found in box truck at impound determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 7, 2011 av 30. Name and address of person who completed cause of death (Item 23a)

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State

31. Date filed (Month Dev. Year) 2011

OCME

Assistant Medical Examiner

Carol Allan, MD

32. Registrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 19B PER FH C917 7-13-11 VT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. L. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30PM **Physician** ones or a thea A 10 2011 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner -Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours Min. 01-16-1927 MD Director 220-20-6243 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show other traumatic event, the Medical Examinar must be notified at ty⊡Yes 2 ☐ No Director BALTIMORE MD 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4408 BELVIEU AVENUE 21215 USA "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify: BLACK 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY ADM. CLERICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PATSIE ALEXANDER HENRY STRAYHORN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
709 CREENWOOD RD. BALTIMORE NAT. CEMETERY 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau 709 GREENWOOD RD, BALTIMORE 21208 MURIEL JONES/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 ■ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) METRO/BALTO. NATIONAL 7-11-2011 BALTIMORE MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. INC 21. Signature of Funeral Service Licensee a 1701 LAURENS ST., BALTIMORE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 30 /Medical Due to (or so consequence of): Examiner 1 ilu. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760% Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🔲 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a d be detached for □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 2 □ No 3 ☐ Probably 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 28b. Time of Injury 27. Morner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Jepital c. 4 hours after dec. Peral Director: Andria in by the fur 1 Natural 5 Pending 1 ☐ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Directory 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) DOQ1730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 N. Belledere BUR 1 ARIS 31. Date filed (Month, Day, Year, State 1 3 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22208 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ ndew Month Medical 4a. Facility Name (if not institution, give Location of Death 4c. County of Death **Examiner** A Wiedica MO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours **1**X∏ M 2 □ F Director 264-46-251 79 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Xes 2 No MD NA 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 1151 North Stricker Street U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Yes, Give 2 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade 3yrs Pathologist Medical Examiners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Knight Hattie Mae Craiq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212171151 North Stricker Street, Baltimore, Doris Knight-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 7/12/2011 Owings Mills, Garrison Forest 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Sig of Funeral Service License Ave. Baltimore, Md 23a. Part 1. Enter the disease, or complications that shock, or heart fature. List only one cause on ear Immediate Cause (Final saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Ph sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Exami The law requires that the death certificate be executed Cause (Disease or ii that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lateral Sciencsis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dysphagia 24a. Was an autopsy performed? Yes 2 Jas this certificate h 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No 1 Tyes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 25588 MD 7/3/11

Registrar

State

Lauren

31, Date filed (Month, Day, Year)

JUL 1 3 2011

10

32. Registrar's Signature

N. Greene Street

Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD

Hawkins

			For State	State of N	/laryland		artment of H		nd Mental		_			
			Registrar 1. Decedent's Name (First, Middle,	(ast)		Cei	tificate of D	eath	2. Date of		. No. 2 0	\sqcup	22	209
Е	Physicia			Larry S	Samue	l Kan	Sr		Z. Date of Month	1	Day 13, 2011	Year	3. Time of 7:14a	f Death M
	Medic Examin		4a. Facility Name (if not institution,			i ivani	4b. City, Town, or	Location of D	Death		4c. County of	f Death		
				oll Hospice - Do					estminster			Car	roll	
П	Funeral Director		,	3. Sex 7. A 1 X M 2 □ F	ige (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mont	h, Day, Ye.	ar)	Count		or Foreign
			220-56-9108 Usual Residence of Decedent		59				l_Ar	or 25, 1	952	IV	laryland	
	ryland -f sho ied at	ctor	10a. State 10b. County		10c. City,	Town or Lo		***				1	d. Inside Ci	
	ne Ma or 28a notif	Dire	Maryland B 10e. Street and Number	altimore			10f. Zip Code	altimore		100	. Citizen of W	hat Caun		2 🗆 No
	with the	Funeral Director	4 Rand Court				10.1 2.10 0000	21244	1	109	. Oilizeii Oi W	U.S.A		
	death items	Fun	11, Marital Status	12. Was Decedent Armed Forces	?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin	? (Specify Yes or	No-	14. Race			
36	al", or	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 In the second of the s	No No		☐ Yes 2 🗓 No		ŕ	,	Specify:	, White, e	lack	
2-0	hours natur	Completed	15. Decedent (Specify only highes	's Education		16a. Decec	ent's Usual Occupa	ation		16	b. Kind of Bus			
121	thin 72 ine. than '	Į Į	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. D	nind of work done done done done done done done done				Ralph De	eChiar	o Enterp	rise
d 2	Hygie other ent, ti	Be	12. Father's Name (First, Middle, La	st)			Mainten	18. Mother's	Name (First, Mic	ddle Maio	den Surname)			
ylan	d be fi Mental arked atic ev	္ခ	Le	on Kane							n K. Price			
Man	shoul		19a. Informant's Name/Relationship	(Type, Print)			g Address (Street a				y or Town, Sta	ate, Zip C	ode)	
e,	and 2 Health tem 2		Isabella Kane 20a. Method of Disposition		20b Pia		Rand Court' I	Baltimore	, Maryland		c. Location - (Pite or To	un Ctata	
E O	Page 1 nent of int: If i		1 🕱 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp	Removal from State		metery, cren	natory or other place	′ i	07/11/ ⁻	- 1		sadena		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign cure channal Service Lic				Name and Address	s of Facility					<u></u>	
	00 = a 0		23a. Part 1. Enter the disease, or o	amplications that square	of the death	Do not onto	Estep B	rothers F Itaw Plac	uneral Serv e Baltimore	ice, P. , Md 2	A. 1217			
5	Physician/		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lin	71107	71 71 (AL.	C A	ry arrest,			Approximat Interval Bet Onset and I	ween
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as	s a conseque	nce of):	HIO	70						
	Examiner	-	Sequentially list conditions,	b. ————								_		
	ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a donacqua	nec on:								
	ate be executed hysician and the burial-transit	I Ex	that initiated events resulting in death) Last	C. Due to (or as	a conseque	nce of):			·					
9	ate be ohysici the bu	edical		d								_		
687	eath certifica attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	of delive	n/	
Box	death ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1	at time of dea		Ectopic pregnancy Other (specify)	/			Mont		,	/ear
0	at the d by th letache		9 Unknown Part II. Other significant condition			ting in the u	derlying cause give	en in Part I	220 [Old tobase	co use contrib	unto to the	anuna of d	ooth?
S, P.	uires th signe Id be c	d by									2 No 3			
Records,	w require s been si 2 should t	Completed								Was an			sy findings a	
Rec	sician: The law certificate has triector, page 2 s	Com							1 1	autopsy performed Yes 2	1?de	ath?	pletion of c	ause or
ita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		<u> </u>	26. Pla		Check only one)			1	1 9 12/17	14.17
<u> </u>	y Physer this eral di	e: 10	27. Manner of Death	28a. Date of inj	tient 2 Element 2 Element 2	R/Outpatien 8b. Time of	28c. Injury	4 L Nursi	ng Home 5 🗆 I		6 Other		KOSA	(A)
ono	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investiga		ay, Year)	injury	work?				,,, oooa,,oo		, , , ,	
Division of Vital	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of In	jury - At hom tc. <i>(Specify)</i>	e, farm, stre	et, factory, office			on (Street Town, St	and Number ate)	or Rural	Route Numb	er,
	spital neral I	edical	29a. Certifier 1 Certifying P	hysician: To the best o	f my knowled	dge, death o	ccured at the time.	date and plac	ce, and due to th	e cause(s	and manner	as stated		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	(Check 2 Medical Exa	aminer: On the basis of durse Practioner: To the	examination a	ind/or investi	gation, in my opinior	n, death occur	red at the time, d	ate and pl	ace, and due t	o the cau	se(s) and ma	nner stated.
	5 viit		29b. Signature and tiffe of certifier	10 Karlo	1/ 1	W	29c. License	number 37	8	29d.	Date signed (Month, D	ay, Year)	
			30. Name and address of person wh	no completed cause of	death (Item 2	3a) (Type, Pi				0	/ >		_0 (1	
J			30 Name and address of person when he was filed (Month Pau Year)	-			ar wa	STILL	NSTE	CM	1) 2	1/3	57	
	Stat Registra	_	31. Date filed (Month, Day, Year) JUL 1 3 2011	again 32. Registr	rar's Signatur	and	•							
_		_		-					-					

Physi Me Exar

Fune Direct

	V	Please	Type or Pri						_		_	e.	
	-	For State Registrar	State of M	-	Departme <i>Certifica</i>			ind Me		giene Reg. No		1	22210
		Decedent's Name (First, Middle, La.	st)						2. Date of Dea	ath	201	1	3. Fime of Death
cian dica	al .	Henry Joseph Kr 4a. Facility Name (if not institution, give			T., 0:	T		I D th	Month 07	1 Da		11	9:35 AM M
nine	r		,				r Location of	Deam		40	County of D. Harfo		
al		2320 Dunwood Lar 5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last birti	hday) If Un	oppa der 1 Year			8. Date of Birt		9.	Birthp	lace (State or Foreign
or		217–12–0197	XIM 2□F	88	Yrs. Month	ns Days	Hours	Min.	097267	192	2 1	Count Mar	vland
٦	. 1	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	14:							L	04 1-14-03-1-4-
- -	cto	MD Harfor	-A	Joppa								- ['	0d. Inside City Limits 1 ☐ Yes 2 🄀 No
	를 -	10e. Street and Number		оорро		Zip Code			Т	10g Ci	tizen of What	Coun	
1	Funeral Director	2320 Dunwood Lar	20			21085				_	.S.A	Coun	uyr
1	ğ	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Dec	cedent of H	lispanic Orig	in? (Speci	fy Yes or No-	$\overline{}$	14. Race - A	merica	an Indian,
ľ	by F	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 📉	No			an, Mexican,	Puerto Ri	ican, etc.)		Black, W		
-	eg	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 □ Yes	2.00 No	Specify:				Specify:	Whi	te
1	Completed	15. Decedent's E (Specify only highest gr		16a.	Decedent's Us (Give kind of v	work done	during most	of working	,	16b. k	(ind of Busine	ss Ind	lustry
1		Elementary/Seconday (0-12)	College (1-4 or	· .	iife. DO NOT (Carpent	·				1	Puggle	e C	onstruction
	as l	17. Father's Name (First, Middle, Last)		1_0	arpenc	CT_	18. Mother	r's Name	First, Middle,			5 0	OID CI GC CIOI
	Henry John Kraus Grace Anderson												
	19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												iode)
		Margaret C. Kra	aus (wife) 23	20 Dun	wood	Lane -	- Jop	pa, Ma	ryl	and :	210	85
		20a. Method of Disposition 1	Removal from State		Disposition (Ny, crematory o		ce)	Da	ate	20c. L	ocation - City	or To	wn, State
1		4 Donation 5 Other (Speci		St. Jo									Maryland
ouce,		21. Signature of Funeral Service Licen	see						r. Lass Kingsv				Home, P.A. and 21087
	7	23a. Part 1. Enter the disease, or com	plications that caused	the death. Do n	-						-	T	Approximate
n/		shock, or heart failure. List only o											Interval Between Onset and Death
al		disease or condition resulting in death)	Due to (or as	a consequence of	of):							+	weeling
er	្គ	Sequentially list conditions.	b. Dyent	a consequence of							_	1	3 weeks
7	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	· ·		of):							Ι,	4 .
	ixa	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as	a consequence of	of):							+	years
- 11	_ ı	,		,	,								
ľ			d						-				
1	<u></u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	2 □ Estan	io prognan	CV				23d. Date of	delive	ery
		in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a		5 Other		Oy .				Month		Day Year
l	<u></u>	9 ☐ Unknown Part II. Other significant conditions of		out not resulting i	n the underlyin	or cause d	ven in Part I		220 Did to	haaaa	ugo contribute	n to th	e cause of death?
	2	MSC-D	January 15 dodin's	at the foodstang to		.g g					_		pably 4 Unknown
	ete 	Caria							24a, Was a		-		psy findings available
	Completed by Physician/Medical	4540							autop perfo	sy rmed?	prior death	to cor	npletion of cause of
	Se Re	25. Was case referred to medical				26. P	lace of Death	(Check c	1 Yes	2	o 1 □	Yes	2 No
	0 0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Ou	tpatient 3 🗆	Oth	or		ie 5 🗷 Resid	lence (6 ☐ Other (St	necify)	
		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ry 28b. T	ime of	28c. Inju	y at		3d. Describe h				
	<u>≅</u>	2 Accident Investigatio 3 Suicide 6 Could not be	n	,, , , , , , , , , , , , , , , , , , , ,	M		Yes 2 🗆 I	No					
	Medical Certificate:	4 Homicide determined		ury - At home, far c. (Specify)	rm, street, fact	tory, office		28	3f. Location (S City or Tow			Rural	Route Number,
	gal	29a, Certifier 1 Certifying Phy	rsician: To the best of	my knowledge	death occured	at the time	date and a	lace and	due to the es-	isele) c	nd manner co	etata	
1	Jedi	(Check 2 L Medical Exam	iner: On the basis of e se Practioner : To the	examination and/o	r investigation,	in my opini	on, death occ	curred at the	ne time, date a	nd place	e, and due to t	he cau	ise(s) and manner stated.
- [3	2	29b. Signature and title of certifier				29c. Licens		piaco,			te signed (Mo		

20

State Registrar Winds Klars 2 31. Date filed (Month, Day, Year) JUL 13 2011 5701 Kenwood

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D3/291

But

7/11/11

no 21206

James A. Loftor	1	1- For State	tate of Maryl		partment of			Mental I		20	11 22211
Physici	an/	1. Decedent's Name (First, Midd	dle,Last)						2. Date of Dea		3. Time of Death
Medical Exami	ner	James A.	Lofton						July 2, 20	Day Yea)11	1540 hrs
8		4a. Facility Name (if not instituti University Hospital	on, give street and nu	ımber)				cation of Dea	ith	4c. County of	of Death
Funeral		5. Social Security Number	6. Sex	7 Age /In yes	. last birthday)	Baltir		If Under 24H	re le Data of Pi	N/A	9. Birthplace (State or
Director			1. X M 2. F			Month		Hours M	in.		Foreign
		216-29-8821 Usual Residence of Decedent	IZM Z_F	21	L Yı	S.			6/28/	1990	Country) Md.
any		10a. State 10b. County		10c. Cit	y, Town or Loca	ation					10d. Inside City Limits
and show	ŏ	Md.	N/A	E	Baltime	ore					1 XYes 2 No
Maryl 28a-i	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of Wh	at Country?
hours after death with the Maryland "natural", or Items 23a or 28a-f show Examiner must be notified at once.		1408 Ward S					2123			USA	
tems	uneral	11. Marital Status 1 XNever Married 2 N							Specify Yes or No to Rican, etc.)	0- 14. Race White	- American Indian, Black, e, etc.
ter de	Ŀ		1 Yes	2 X X No	1	Yes 2	X No s	specify:		Specific	Black
2 hours afte "natural", Examiner	d by	15. Decedent's Education (Spe	or Dates			nt's Usual	Occupation	(Give kind of		16b. Kind of Bus	
	lete	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during r	nost of wo	rking life. Di	O NOT use re	tired)		
903 within iene.	Completed	12			St	tude	nt			School	
filed of the state of the		17. Father's Name (First, Middle							•	Maiden Surname)	
212 uld be Menta marko	o Be	James Lofto 19a. Informant's Name/Relations			19b. Mailir	a Address	(Street ar	Cimber or	cly Jon	Les ober City or Town	n, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		James Lofto			1					ore, Mo	
Te, Te		20a. Method of Disposition			Place of Dispo crematory or o	sition (Nar	ne of cemet	ery,	Date	20c. Location -	City or Town, State
Pages ent of		1 XBurial 2 Cremation 4 Donation 5 Other S	_	om State We	•	. ,		7 7/9	7/2011	BAltir	more, Md.
alti mit. partm porta	18	21. Signature of Funeral Service			H.	Name and	Address of	Facility	Funera	1 Sarv	ice DA
		Lloyd M	Colley		13	300°	Eutav	Plac	e, Bal	timore	ice, PA. , Md. 21217
Physician // Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		h. Do not enter	the mode o	of dying, suc	ch as cardiac	or respiratory arr	est, shock, or hea	rt Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gu Due to (or as a								Death
-		Sequentially list conditions,	b.	consequence	01).						
	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	of):						
	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):	_					-
cuted	9		d			_					
D, be executed sician and winal - transit	dical	UNPENDED	AMENDED								4.8.7
ox 68760 eath certificate b attending physi		IF FEMALE: 23b. Was decedent pregnant in the		outcome of preg			. 🗀			23d. Date of c	
Box 6876C death certificate he attending phys	Ciar	past 12 months?	I Live bi	irth ant at time of d	ooth -	etal death ther (Spec		Ectopic pregn	ancy	Month	Day Year
Boy e death the att	Physician/M	1 Yes 2 No 9 Uni	known 9 Unkno	wn	<u> </u>	iller (opos	,			1	
b.O. that the	by P	Part II. Other significant condit	ions contributing to	death but not	resulting in the	underlying	cause giver	n in Part I.			oute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	Pe				-						Probably 4 Unknown
cord aw req aw red as bee	bet								24a. Was autop	sy pr	fere autopsy findings available for to completion of cause of
Rec The l	Completed								1 Yes		eath? ✔ Yes 2 No
Division of Vital Rec pital or Attending Physician: The cours after death. teral Director: After this certificate filled in by the funeral director, page	Be	25. Was case referred to medica examiner?			1		IOth.	Death (Check			
Physi Physi er this	욘	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Ir		ER/Outpatient		8c. Injury at			Residence 6	
on of ading P. th.	اقِ	1 Natural 5 Pend	(Month	Day,Year)	0950 hrs	rijury 2	_	2 No	Subject shot		1
ivisio	icat	2 Accident Inves	stigation 28e Place	of Injury - At h	ome, farm, stree	et, factory,			28f. Location (S	Street and Number	r or Rural Route Number, City
Divis ospital or A hours after uneral Dire y filled in b	Certification:	Odioido ott.	a not be	Sidewalk		,		0, 111	or Town, St		
Ho Fun		29a, Certifier 1 Certifying Ph	nysician: To the best	of my knowled	lge, death occur	red at the	time, date a	and place, and	due to the cause	e(s) and manner a	as stated.
To the Hospital within 24 hours a To the Funeral completely filled	Medical		miner:On the basis o and manner st		and/or investigat	tion, in my	opinion, dea	ath occurred	at the time, date a	and place, and du	e to the cause(s)
	Ž	29b. Signature and title of certifie	r	0		29c.	License nu				d (Month, Day, Year)
		Mate Wor	onir-	Yolk	de us		O.C.M.E			July 5, 2011	
(ſ	 Name and address of person Patricia Aronica-Pollal 		•	•	900 \\	Raltimas	a Stract 5	Rollimore AAT	21222	
Sta	ate.	31. Date f 44 Month, Quy (sa)		istrar Signat			Dailillion		Janumore, IVIL		
Registi		JOE T. 2. ZOV	Levens	10.00							

			For State Registrar	State of Marylan		artment of F tificate of D		and M		iene _{eg. 1} 20		22212	
	ŕ	Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death			
	Physicia Medic		Maming C. Lacky					July 5, 2011 Year 12:40			12:40 P M		
- 7	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De										
\	— <u>L</u>		7889 Stone Hearth 5. Social Security Number 6. Sex	and foliable along the	Seve1		24 Hrs	8. Date of Birth	Anne Arunde 1 3. Date of Birth 9. Birthplace (State				
	Funeral Director			7. Age (In yrs. Ia		Months Days	Hours	Min.	Month, Day, January 2	Year) 1950		hilippines	
			Usual Residence of Decedent							,			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County		y, Town or Loc							10d. Inside City Limits 1 Yes 2 X No	
		Director	Maryland Anne Aru	ndel	Seve	10f. Zip Code				0g. Citizen of V	Mhat Co		
			7889 Stone Hearth		2114		'	United States					
		Funeral		12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi	spanic Orig	gin? (Spec	cify Yes or No-			rican Indian,	
Baltimore, Maryland 21215-0036		by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Yes, specify Cuba			Rican, etc.)	Blac Specify:	ck, White	e, etc. Sian	
5-0	2 hou "natu edica	plet	15. Decedent's Education (Specify only highest grade completed)			ent's Usual Occup	t of workir	g 16b. Kind of Business Industry			Industry		
121	thin 7 ane. than he M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		omemaker				Own	n Hoi	me.	
d 2	should be filed wi and Mental Hygie is marked other aumatic event, ti	(a)	17. Father's Name (First, Middle, Last)		11	Omemaker	18. Moth	er's Name	(First, Middle, N			-	
/lan		To	Inocencio Calica				01	ympia	a Marzan	1			
lan			19a. Informant's Name/Relationship (Typ	e, Print)		g Address (Street a							
2,	and 2 Health Pm 27 her tr		Eugene L. Lacky/Hu			Stone Hea	arth l						
Jore	ge 1 a nt of H : If ite or otl		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Removal from State Ma	Place of Disport emetery, crem LTV Land	sition (Name of hatory or other place Veteran Crownsvi	s I.	Ju1y	11.	20c. Location -	•		
Ħ	artmer artmer ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		00	Name and Address	e of Engilit	2011				e, Maryland	
Ba	permit Depar Impor any in		1 /ARIEUT	600 MO1	386 D	onaldson 411 Annaj	Fune: olis	ral H Roac			yla yla	P.A. nd 21113	
			shock, or heart failure. List only one cause on lach line.								Approximate Interval Between Onset and Death		
n da	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	er, metasta			stahe	apic		Onset and Death			
	Examiner		Toolaking in doubly	uence of):	,								
	cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Janea city:									
			cause. Enter Underlying Cause (Disease or iinjury that initiated events										
		E E	resulting in death) Last	Due to (or as a consequ	uence of):								
90	ate be ohysic the bu	dical		d							\rightarrow		
687	ath certifica attending p for use as i	···	IF FEMALE:	3c. If yes, outcome of pregna	ncy					22d Do	to of de	liven	
P.O. Box 687	aath certific attending I for use as	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Unknown							23d. Date of delivery Month Day Year			
Э.	the de by the ached	hysi	9 Unknown	9 Unknown									
<u>P</u>	ires that the dea signed by the a Id be detached fi	by P	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part	1.		. 1		the cause of death?	
ds,	quires en siç ould b	ted	1 □ Yes 2 💆 No 3 [3 🗌 P	robably 4 🗌 Unknown	
24a. Was an autopsy								sy	24b. Were autopsy findings available prior to completion of cause of				
Female: Sab Sab						death?	s 2 No						
ital	s ician certifi rector	Be (25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		_ lOth	ace of Dea er:	-					
of V	y Physer this eral di	e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injun	4 <u>U</u> Nu yat		me 5 Reside 28d. Describe ho			ify)	
ou o	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical Certificate:	1 Natural 5 Pending 2 Accident Investigation	injury work? M 1 □ Yes 2 □ No									
Visi			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	pital o									and due to the eques(s) and manner as stated			
	No the Hospital within 24 hours a To the Funeral C completed filled		(Check 2 Medical Examin	cian: To the best of my knowler: Practioner: To the best of my	n and/or invest	igation, in my opinio	on, death o	ccurred at	the time, date an	d place, and du	e to the	cause(s) and manner stated.	
	To the virthing company	-	29b. Signature and title of certifier	1.	1:	29c. License	e number	150 /6		9d. Date signe			
			aper.		/	1000	641	18	(ruly.	+1	2011	
V			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, P	2 Host	ritor	1)	2011	Glent	Siro	2011 nie,MD	
	Stat		31. Date filed (Month, Day, Year)	32/16, "strar's Signat	ture					20000		-/	
	Registra	ar	JUL 1 3 201	1 Chewa	1. Ash	Les 1				_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Jul Physician/ 2611 12:15 AM John Nelson Leatherwood Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospita Laure Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F Month, Day, Ye February 4, Country) Maryland 81 **Director** 214-26-5564 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Anne Arundel Maryland Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21113 457 Monterey Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🙀 Married Completed by Yes 2 No 1951-Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify: White 3 Widowed 4 Divorced Year or Dates. 1953 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) 2+ Supervisor Gas & Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Morley H. Leatherwood Wilhemina Ruth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 457 Monterey Avenue, Odenton, Maryland 21113 Alberta Leatherwood/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place West Arunde) 20a Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Toremation 3 Removal from State 4 Donation 5 Other (Specify) Odenton, Maryland Crematory 21. Signature of Funeral Sovice Lice vee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory,
1411 Annapolis Road, Odenton, Maryl M01386 Part 1. Enter the disease, or shock, or heart failure. List o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part one cause on each line Immediate Cause (Final Pancreatic Cancer Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ulmonary Secure tielly list exactly as Examiner if any, leading to immediate cause. Enter Underlying Acute Renal ohysician and the burial-transit The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

leral Director: After this certificate has liflled in by the funeral director, page 2 s performe Yes 2 N 1 ☐ Yes 2 🗙 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dusen Rd

7300 Van

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#26PETPHTS, C917, 7/13/2011, WS opies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend #17 Per FH C926 4/11/2012 JH

Certificate of Death for State Registrar Reg. N. 20 22214 I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month Day Physician/ Mabel Claire Linkous 06 2011 $15:05p^{M}$ **Medical** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 799 Oakdale Circle Anne Arundel Millersville If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8 Date of Birth 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🔀 F Days Hours 07/01/1923 234-36-8579 VA Yrs. Director Usual Residence of Decedent 28a-f shov Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 ☐ No VA Tazewell Bluefield ò 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a U.S.A. 303 Virginia Avenue 24605 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last)

Burnette Be 18. Mother's Name (First, Middle, Maiden Surname) ည Edward James Barnette Stella Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 i any injury or other tra Patricia A. Lennon (Niece) 799 Oakdale Cir., Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Grandview Mem. 7/2/11 Bluefield, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun val Service Licensee 22. Name and Address of Facility Peery & St. Clair F.H. 111 Bon Bolt Ave., Tazewell, VA 24651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresplaces, or heart failure. List only one cause on each line. 25 Interval Between Immediate Cause (Final Onset and Death Physician/ amplications disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neumonia Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): and I-transit Exami death certificate be executed Due to (or as a consequence of): resulting in death) Last burial physician the burial Physician/Medical as IE EEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' 1 🗌 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 X Other (Specify) House 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of injury (Month, Day, Year) 12/01/2010 27. Manner of Death 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 Natural
2 Accident 5 Pending thin 24 hours after death.

the Funeral Director: Afte mpleted filled in by the fun FAIL at home 1 \(\text{Yes} MANOUNIN Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 799 Oakdale Civile Miller VIII, MD determined Home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 1 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30/2011 R118354 10% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amy Schuler Oak Point 7900 ct MD 21122 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 22215 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20°11 Ju™n₩ Joseph Lavonis 6:27p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>3602 Mountain Road</u> Pasadena Anne Arundel 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Ma Menth, 25 Yelr) 926 216-20-8894 85 Pennsylvania **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2XXNo Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122-2023 3602 Mountain Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Brewery worker Brewery Be (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Joseph G. Lavonis Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8569 Beacon Point Drive Pasadena, Md.21122 Donald Dembeck / Friend 20a. Method of Disposition Julyte 20b. Place of Disposition (Name of 20c. Location - City or Town, State Holy Rosary Cem. 1 \(\bar{\text{M}}\) Burial 2 \(\Bigcup \) Cremation 3 \(\Bigcup \) Removal from State 13, 2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signatore of Funeral 9 201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death Physician/ Dhai disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any Lading Is immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to or as a consequence of Examir and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death the signed by the not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page 2 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 Yes

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, this certificate Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death n 24 hours after death.

le Funeral Director: After the bleted filled in by the funeral 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural Accident 5 Pending work М 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2

DHMH 17 Rev 7/2009

(Check

29b. Signature and

only one

Cer

1 3 2011

32. Registrar's S

clical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Typing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	1	For State Registrar Decedent's Name (First, Middle, L.		ar yrai R			t of Health and e of Death		Reg. N	0011	22211	
nysician/ Medical Examiner	F	Ielene . Facility Name (if not institution, given	E	•			Call Town, or Location of De	2. Date of Month O7	1	Day Ye 1 20 4c. County of E	1 04:45a	
		Gilchirst Hospice				r	owson			Baltimore		
neral ector	2		1 M 2 F	e (In yrs. Ia:	st birthday) Yrs.	If Under Months		in. (Month	Day, Year,		Birthplace (State or Fore Country) MD	
dical Examiner must be notified at pleted by Funeral Director	$\overline{}$	la. State 10b. County MD NA			Town or Loc		-				10d. Inside City Lim	
er must be notified at Funeral Director	10	10e. Street and Number				10f. Zip	Code	Citizen of Wha	1 X Yes 2 C			
unera	11	2500 West Belvedere Ave 11. Marital Status 12. Was Decedent Ever in U.3			13 M	las Deced	21215 lent of Hispanic Origin?	(Specify Yes or	No- 14. Race - American Indian,			
ed by F		1 ☐ Never Married 2 ☐ Married 3 ☐ X Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates.			If	Yes, spec	ify Cuban, Mexican, Pu		Black, White, etc. Specify: Black			
o Be Completed	F	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)			(Give k	ent's Usua ind of wor NOT use	al Occupation of done during most of v retired)	vorking	g 16b. Kind of Business Industry			
Be Co	17	2th grade . Father's Name (First, Middle, Last	lyr				tician Adie			Nursing Home		
안		ance Ross	ast) 18. Mother's Name Mary Sha						ne (First, Middle, Maiden Surname)			
To Be Com		Ja. Informant's Name/Relationship			1						, Zip Code) 21117	
		eronica White a. Method of Disposition			ace of Disposemetery, crem	ition (Nan		Apt 7			y or Town, State	
	L	1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			On-Si	•		15/201	Ll Ba	altimo	re, Md	
once.	21	. Signature of Funeral Service Lice	ach		Ma	rch	d Address of Facility F/H West Jabash Ave	D-14			21215	
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Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
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l by P	Pa	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						1	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknow			
Completed								24a. V	Vas an utopsy erformed?	24b. Were prior deat	e autopsy findings availal to completion of cause h?	
o Be Comple		. Was case referred to medical examiner?	11				26. Place of Death (C		es 2	No 1 L	Yes 2 No	
e: To	27	1 ☐ Yes 2 No . Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of injury 28b. Time of				OA Other: 4 Nursin	Home 5 Residence 6 Other (Sp. 28d. Describe how injury occurred			pecify) hospic	
Certificate:		1 Natural 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be addressing of determined.						28f. Locatio	on (Street a	and Number or	Rural Route Number,	
Medical Co	29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.										s stated.	
9 I Q		(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis of e	xamination	and/or investi	gation, in r eath occur	ny opinion, death occurr red at the time, date and	ed at the time, da	ate and place to the cause	ce, and due to e(s) and manne	the cause(s) and manner s r as stated.	
₩		29b. Signature and title of certifier 29c. License number 29c. License number					303 July 11 Zoil					
completed filled in by the funeral director, page Medical Certificate: To Be Com	29	> Afrail	NO				9302		10	17	0011	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N 20 22217 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201 1 Year July 9 4:13 A M McClendon Medical Allan Thor 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Baltimore Towson Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Month, Day, 1 🔀 M 2 🗆 F Months Days Hours Min Director 49 **219-76-133**8 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 21207 U.S.A. 2008 Richglen Drive Apt 2A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. <u>6</u> 1 Never Married 2 X Married 1 Yes 2
If Yes, Give
Year or Dates 2 No 21215-0036 "natural", 1 Tes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Dept Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene 2th grade Service Worker Social Services na Be Maryland permit. Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel McClendon Sr. Mattie Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Health tem 27 Michele McClendon-Wife 2008 Richglen Drive Apt 2A, Baltimore, Important; If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₫ 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Woodlawn Cemetery 7/16/2011 Woodlanw, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi 1. Linnsee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, as Baltiore, md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 12H Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine 24 4 the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last consequence of 30 days Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

060406

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22218 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 1 0 Day 20^{Year}1 :25pM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min **Director** TLIH Usual Residence of Decedent or items 23a or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location Director 1 Yes 2 □ No MURR 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry COAST life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OIN e Be Page 1 and 2 should be filed vent of Health and Mental Hygent: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) City or Town 19b. Mailing Address (Street and Nu EANUR ACKI 611 permit. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other: other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or 15 4 Donation 5 Other (Specify) Name and Address of Facility

1046 Rows Signature of Funeral Service Licens BUNGA 16 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a each line. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of) cause. Enter Underlying Cause (Disease or linjury Exami and that initiated events resulting in death) Last Due to (or as a consequence of) burial-t ending physician ause as the buriat-Physician/Medical that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ō Year Month Dav Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown the P.O. I is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital s after death.

| Director: After this or
d in by the funeral dire 2 No 1 Tes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined thin 24 hours a...
to the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within 2 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year, 30. Name and andress of person who completed ause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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11. Date filed (Month, Day, **IUL 132011**

21208

			For State Registrar	State	of Maryla	nd / Depa <i>Cer</i>	artment of F tificate of L	Health and I Death	Mental Hy	giene Reg. No.		22219	
	Divisionis	/	Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath		3. Time of Death	
	Physicia Medic		MARGARET VII						JULY	9 ^{ay}	2011	3:35 P M	
	Examin	er	4a. Facility Name (if not institution					Location of Death	1	4c. Count			
	Funeral		FOREST HILL 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	FOREST If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	FORD 9. Birthp	place (State or Foreign	
	Director		215-22-1526	1 □ M 2 🔀 F	83	Yrs.	Months Days	Hours Min.	Sep. 9	1927	Mary	land	
	and show lat	or	Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Loc	cation				1	0d. Inside City Limits	
	Maryla 28a-f otifiec	Top. County 10c. City, Town or Location									1 🗌 Yes 2 🔀 No		
	10f. Zip Code 10g. Citizen of Wh								What Coun	itry?			
	ems 2	Funeral	3803 A Memory 11. Marital Status		edent Ever in U	J.S. 13. V	21009 Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-	USA 14 Bar	ce - Americ	an Indian	
36	fter de f, or it amine	þ	1 Never Married 2 Mar	If Von Ci	2 🔀 No	l I	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc.		
ğ	ours a atural cal Ex	eted	3 Widowed 4 Divorced	Year or D						Specify	WI	ite	
215	n 72 h e. ian "n Medi	Specify: Specify:								susiness inc	dustry		
21	d with lygien ther th	Be Co	12			Homen	naker			Own Ho			
Maryland 21215-0036	be file antal H ked of c ever	To B	17. Father's Name (First, Middle, I	,				18. Mother's Nan	, ,		ne)		
ary	The property of the property o									State, Zip C	Code)		
Σ	nd 2 s lealth a m 27 i			ıghter			Bellflow	er Ct., I	Edgewood	, Maryl	and 2	1014	
			20a. Method of Disposition 1 ☐ Burial 2X Cremation		n State		natory or other plac		Date	20c. Location	- City or To	wn, State	
Ħ	permit. Page Department Important: If any injury or once.		4 Donation 5 Other (\$21. Signature Funeral Service L		Hi		Service Co . Name and Addres		3-2011 COmas F	Towson			
ñ	Dep Imp any		Darbar	a Pu	dis	\	317 Coke						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between		
	Physician/ ✓ Medical	ì	Immediate Cause (Final disease or condition resulting in death)		eno						_	Onset and Death	
	Examiner			Due to	(or as a consec	quence ot):							
-	7 ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence of):							
	ecuted and I-trans	Exan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to	(or as a consec	guence of):					-		
20	cate be executed physician and the burial-transit	edical Examiner	,	d.	•	,							
۵/۵	tificate ng phy		IF FEMALE:	1								-	
POX PS	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as		23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregri Birth 2 Fe mant at time of	tal death 3 🗌	Ectopic pregnanc	у			ate of delive	ery Day Year	
ă.	the degraphed by the grached suched	hysic	1 Yes 2 No 9 Unknown	9 Unk		dealii 3 L	Other (specify)						
л. Э.	s that i gned b	ρ	Part II. Other significant condition	ons contributing to d	leath but not re	esulting in the u	nderlying cause giv	en in Part I.				ne cause of death?	
os,	equire een sij	eted					_					pably 4 🗆 Unknown	
Vision of Vital Records,	e law r s has b ge 2 sl	Completed							24a. Was a autop perfo	rmed?	prior to cor death?	psy findings available mpletion of cause of	
T T	an: Th tificate tor, pa	Be C	25. Was case referred to medical				26. Pla	ace of Death (Chec	1 L Yes	2 No	1 Yes	2 No	
VIC	hysici his cer Il direc	္ရ	examiner? 1 Yes 2 No			ER/Outpatien	t 3 🗆 DOA Othe	er: 4 Nursing H	ome 5 Resid	lence 6 🗆 Oth	er (Specify))	
10 0	ding P h. After t funera	ate	27. Manner of Death Natural 5 Pendir	ly .	of injury oth, Day, Year)	28b. Time of injury	28c. Injury work' M 1	∕at ? Yes 2 □ No	28d. Describe h	ow injury occurr	red		
SIO	Atten	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place			eet, factory, office	res 2 LINO		treet and Numb	er or Rural	Route Number,	
2	ital or irs afte ral Din led in	- 1		build	ing, etc. (Speci	<i>Ty)</i>			City or Tow	n, State)			
•	Hosp 24 hou Fune eted fil	Medical	(Check 2 L Medical E	Physician: To the base	sis of examination	on and/or investi	igation, in my opinio	n, death occurred a	t the time, date a	nd place, and du	e to the cau	use(s) and manner stated.	
	To the within To the Comple		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best of n	ny knowledge, d	29c. License			e cause(s) and m 29d. Date signe			
P			David 50)			235.	275		747 1	1,2011	/	
	9		30. Name and address of person of DAVID DUNN ~ 6					2 MD 21	014				
	Stat	e	31. Date filed (Month Pay, Year)	32.6	egistra	active .	DEU WIL	19 FID 21	014				
	Registra	r,	JUL 135011 19	How !	• "								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,17,20a-c,22 per Th 8918 8-10-11 vt State of Maryland / Department of Health and Mental Hygiens 1 | 22220 For State State Registrar amend 6 per b.c. g922 12/9/14 extificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 04 2011 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Balt and Medical Cente JXX 101 Iniversity of 71000 If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** urity Numbe = **7,098** Day: Hours Min. 1 XM 2 F 2011 Maryland April 14, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show event, the Midical Exercions count be notified at 1 ☐ Yes 2 X No MD Baltimore Brooklyn Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3449 Round Road 21225 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give items ; Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black ō, 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ss 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked College (1-4or 5+ INFANT Elementary/Secondary (0-12) INFANT INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tenaio Newton Larry M. Newton Jr. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3449 Round Rd; Brooklyn, NY 21225 Tenaio Newton - mother Item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If It any injury or or 1 Burial 2 Cremation 3 Removal from State Ardent Cremation Inc. 8-4-11 Hanover, Md. 4 Donationin state un al Service licensee 22. Name and Address of Facility State Amatomy 6009 Harford Rd Marzullo Funeral Chapel Baltimore, MD 21201 21 21. Signature of 21201 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final solmonoru **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner elyonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ne burial-transit Exam and Due to (or as a consequence of certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐Yes 2 No Attending Physician: Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No Inpatient 2 ER/Outpatient 3 DOA 1 TYes ို Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day, Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 29 Suthaveenestreetsmit 110, Baltimore, mo aig

State Registrar Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

w p. gaves

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. NZ U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Physician/ RAH Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Northwest Hospital 8. Date of Birth (Month, Day, Year) If I Inde If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral 1 M 2 G Months Director 65 247-86-8185 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director r 28a-f sh notified a 1X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be with 1 Funeral 2914 Edgecomb Circle South 21215 U.S.A. be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Š 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: SpecifyBlack If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Cup Co Page 1 and 2 should be filed with ment of Health and Mental Hygier ant: If item 27 is marked other t 12th grade Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Julia Caldwell Richard Pearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Willie Pearson-Brother 2914 Edgecomb Circle South, Baltimore, Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 7/15/2011 Woodlawn, Md 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21. Signature of Funeral Service Licens Baltimore, md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLADDER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as i 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Other (specify) Pregnant at time of death been signed by the s should be detached t g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform 1 Yes 2 No certificate 25. Was case referred to prical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) After this funeral 27. Manne Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Watural injury work? 1 🗌 Yes 2 🗆 No 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu death. Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 7 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

eggy Nedd		1-For State Certificate of Particular State Of Maryland / Department of Certificate of Particular State Of Maryland / Department of Particular State Of			2011	22222
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	g. No. n Day Year	3. Time of Death
edical Exam	iner	Peggy Ann Redd		July 8, 201	1	1424 hrs
		4a. Facility Name (if not institution, give street and number) 4b. Franklin Square Hospital	 city, Town, or Location of Deat Baltimore 	ih	4c. County of Death Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth	n(MM/DD/YYYY) 9. Birt	
Director		216-38-2524 1 M 2 X F 74 Yrs.	Months Days Hours Mir	June 4	, 1937 Foreig	muntry Maryland
wny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
and f show	٥	Maryland Harford Abingdon				1 Yes 2 No
Maryl r 28a-i ed at c	Director		10f. Zip Code	10	g. Citizen of What Cour	itry?
ith the 23a o		3608 Philadelphia Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21009 Decedent of Hispanic Origin? (S	Specify Ves or No.	USA 14. Race - Americ	an Indian Block
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Menta I Hygiene. If the Maryland is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral		s, specify Cuban, Mexican, Puerto		White, etc.	an Indian, black,
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	fes 2 X No specify:		Specify: Blac	k
hours natur	ted I		s Usual Occupation (Give kind of st of working life, DO NOT use re		16b. Kind of Business/Ir	ndustry
D36 thin 72 than than	Completed		ekeeping		Health Ca	ire
5-0(led wi Hygier other		17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, M	aiden Surname)	
MD 21215-0036 d 2 should be filed within 7 thth and Mental Hygiene. n 27 is marked other than numaric event, the Medica	o Be	George Edward Thomas 19a Informant's Name/Relationship (Type, Print) 19b. Mailing A	Maude E	dward Be		Tin Code)
AD 2 shou and N 27 is n	Ĕ		Meadow Valley D			
Te, No. 1 and Health		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or othe	on (Name of cemetery,	Date	20c. Location - City or	
Pages nent of ant: I		4 Donation 5 Other Specify: John Wesley	7 UMC Cem. 7-	16-11	Abingdon,	Maryland
Baltimore, MD 2 pernit. Pages I and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumatic.		21. Signature of Funeral Service Licensee 22. Na MC	me and Address of Facility Comas Funeral H	ome, P.A	•	
Physician	5 9	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	I/ Cokesbury Ro	ad, Abin	qdon, Maryl	and 21009 Approximate Interval
Medical	5 8	failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
cuted ind transit	EX	d.				
60, ate be executed bhysician and te burial - transit	Medical	UNPENDED AMENDED			manus — manus de la	
876(ifficate ng phys		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	I death 3 Ectopic pregna	ancv	23d. Date of delivery Month D	ay Year
Box 6876 e death certificat the attending ph ed for use as the	Physician/	past 12 months? 4 Pregnant at time of death 5 Othe	r (Specify)			-,
by the go	Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
of Vital Records, P.O. Be Physician: The law requires that the de ther this certificate has been signed by the meral director, page 2 should be detached for	d by			1 Yes	2 ✓ No 3 Proba	ably 4 Unknown
v requi	Completed			24a. Was ar		opsy findings available ompletion of cause of
Vital Recolysician: The law his certificate has director, page 2 sl	E			perform 1 Yes 2	ned? death?	
tal F	BeC	25. Was case referred to medical examiner? Hospital: 1 Inspirat 2 FR/Outpatient	26.Place of Death (Check			
Physical directhis	은	1 ✓ Yes 2 No Prospital I Inpatient 2 ✓ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	O DOM 4 Naisi	ng Home 5 R	esidence 6 Other:	
on of ending Phath. or: After the funeral	ţi	1 Natural 5 Pending FOUND: POUND:	1 Yes 2 ✓ No		uto auto collision	
Division pital or Attendir ours after death. eral Director: A	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f, Location (Str	reet and Number or Rur	al Route Number, City
vDi spital hours a neral I	Certification:	4 Homicide determined (Specify) Local Street 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence of the control of the cont		Jones Road an	ite) d Pulaski Highway, V	Vhite Marsh, MD
∼ Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
H 3 H S	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon.	th, Day, Year)
10		Card Holda	O.C.M.E.		July 9, 2011	
N		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltin 	nore Street, Baltimore, M	D 21223		
	ate	31. Date filed (Month, Day, Year) JUL 1 3 2011 August A. Agasta				
Regist	ueli	UUL - D CUIT (LANGE) C. LE COURSE				

	, I OI	epartment of Health and N Certificate of Death	Mental Hygiene 2011	22223
Physician/	1. Decedent's Name (First, Middle, Last) John Arthur Ri	ordon	2. Date of Death Month July 08, 2011	3. Time of Death
Medical Examiner	4a. Facility Name (if not institution, give street and number) 13979 Highland Road	4b. City, Town, or Location of Death Clarksville	4c. County of Deat	
Funeral Director	5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (in yrs. last birthe	Months Days Hours Min.		thplace (State or Foreign units) hington, DC
arf show ied at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Howard Clarksy			10d. Inside City Limits 1 ☐ Yes 2 🏋 No
leath with the Maryland tems 23a or 28a-f shoter must be notified at Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	
, re	13979 Highland Road 11. Marital Status 1 □ Never Married 2 🏋 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 🛣 Married 1 □ Never North Status 1980-89	21029 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- 14. Race - Ame	e, etc.
Maryland 21215-0036 2 should be filed within 72 hours after of the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Examir To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	ecedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)	ing 16b. Kind of Business	Industry
and 21 be filed with shall Hygier ked other t c event, thu	17. Father's Name (First, Middle, Last) Robert Raymond Riordon		Engineeri e (First, Middle, Maiden Surname) M. Aery	ng
Maryl 12 should 1 lith and Me 27 is marl r traumati	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Run 979 Highland Rd., C	al Route Number, City or Town, State, Zi	
altimore, mit. Page 1 and partment of Hea portant: If item y injury or othe	20a. Method of Disposition 20b. Place of cemetery 20b. Place of cemetery	crematory or other place)	Date 20c. Location - City or L6,2011 Arlington,	
Balti permit. Departr Importa any inji	21. Signature of Funeral Service libensee M00773	22. Name and Address of Facility Donaldson Funeral 313 Talbott Ave. L		707-4389
• Enysician/	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or hear tayure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic Mel		or respiratory arrest,	Approximate Interval Between Onset and Death
Medical Examiner	resulting in death) Due to (or as a consequence of Due to, or			
60 ate be executed hysician and the burial-transit dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or irrijury that initiated events resulting in death) Last Due to (or as a consequence of cause (Disease) or irrijury that initiated events resulting in death) Last Due to (or as a consequence of cause)			
60 te be ei hysiciar he buria	d			
Division of Vital Records, P.O. Box 6876 Hospital or Attending Physician: The law requires that the death certifica 24 hours after death. Funeral Director: After this certificate has been signed by the attending plated filled in by the funeral director, page 2 should be detached for use as the decical Certificate: To Be Completed by Physician/Mer	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	olivery Day Year
ds, P.O quires that then signed by build be detailed by PI ted by PI	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to	
Division of Vital Records, ral or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be to be the funeral director.			autopsy prior to performed? death? 1 ☐ Yes 2 🔀 No 1 ☐ Ye	itopsy findings available completion of cause of
Vital hysician hysician nis certifi I director	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	26. Place of Death (Chec	ome 5 🖔 Residence 6 🗆 Other (Spec	~:6.1
ivision of \(\) or Attending Phy after death. Director: After this in by the funeral of in by the funeral of	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation 28a. Date of Injury (Month, Day, Year) in		28d. Describe how injury occurred	aryy
Division tal or Atterns after de al Directo ed in by the all Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Ru City or Town, State)	ıral Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, Medical Certificate: To Be	29a. Certifier (Check children 1	nvestigation, in my opinion, death occurred a lge, death occurred at the time, date and pla	t the time, date and place, and due to the ce, and due to the cause(s) and manner as	cause(s) and manner stated.
To with Cor	29b. Signature and title of certifier Sandy, MD	29c. License number D0071600	July 11, 2	
20+11	30. Name and address of person who completed cause of death (Item 23a) (Tejaswi R. Sastry, M.D. 11065 Li	_{pe, Print)} ttle Patuxent Parkw	ay, Columbia, MD	
State Registrar	31. Date filed (Month, Day, Year) JUL 1 3 2011 32 Registrar's Signatur			

DHMH 17 Rev 7/2009

			For State Registrar	State of Mary		rtment of tificate of			giene Reg. Na 20		22224
	Physicia		Dean Rice					2. Date of De		1 ^Y tar	3. Time of Death 9:43 P _M
	Medic Examin		4a. Facility Name (if not institution, give st	reet and number)		4b. City, Town, E1kt	or Location of Deat	h	4c. County		
ممي	Funeral		Union Hospita1 5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	r If Under 24 Hrs	8. Date of Birl	h	9. Birthpl	ace (State or Foreign
_	Director ≥		177-14-7640 Usual Residence of Decedent		86 Yrs.	Months Days		Jan 22	7925		sylvania
	aryland a-f sho ified at	Director	10a. State 10b. County MD Cecil	10	oc. City, Town or Loc North E					10	od. Inside City Limits 1 ☐ Yes 2 🖺 No
	ith the M 23a or 28 st be not	ral Dir	10e. Street and Number 95 W. Shady Beac	h Road		10f. Zip Code 2190	1		10g. Citizen of V	Vhat Count	try?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral		2. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.	If	Vas Decedent of Yes, specify Cut ☐ Yes 2 🛣 N	Hispanic Origin? (Span, Mexican, Puerlo Specify:	pecify Yes or No- to Rican, etc.)		e - America ck, White, e whi	tc.
Maryland 21215-0036	within 72 hour giene. er than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12) 12		(Give k	ent's Usual Occu ind of work done O NOT use retired acher	during most of wo	rking	16b. Kind of Bu Ceci Scho	1 Cou	
and	be filed vental Hyg ked othe c event,	To Be	17. Father's Name (First, Middle, Last) Wallace S. Rice				18. Mother's Na Anna I	me <i>(First, Middle,</i> B igart	Maiden Surname	3)	
Mary	d 2 should alth and Ma 27 is mar r traumati		19a. Informant's Name/Relationship (Type Dorothy Rice - V		19b. Mailin 95	g Address (Stree W. Shad	t and Number or Ru y Beach I	ural Route Numbe	r, City or Town, S	itate, Zip Ci MD 21	901
Baltimore,	Page 1 and nent of Hes ant: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation T Other (Specify)			natory or other pl		Date	20c. Location -		wn, State
Balti	permit. Departn Importa any inju		21. Signature Funeral Service Licensee Denie	more/s	22.	Name and Addi	ress of Facility St Baltimore	ate Ana St; Ba	tomy Boa ltimore,	rd MD 2	21201
	Physician/		23a. Part 1. Enter the disease, or complishock, or heart fallure. List only one Immediate Cause (Final disease or condition	cations that caused the cause on each line.			ing, such as cardia Pullum		rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a co	onsequence of):						
	ted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	onsequence of):						
09	certificate be executed nding physician and use as the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. On the Funeral Lirector After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of r 1 Live Birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregna Other (specify)				ate of delive	ory Day Year
s, P.O.	res that th signed by d be detac	d by Ph	Part II. Other significant conditions con	9.	not resulting in the u	nderlying cause	given in Part I.	"			e cause of death?
Division of Vital Records,	re law requ e has been age 2 shoul	Completed		COPD			-		osy prmed?		sy findings available inpletion of cause of
tal H	ician: The sertificat ector, pa	Be	25. Was case referred to medical examiner?	ospital:		10	Place of Death (Che	1 \(\sum \) Yes eck only one)	2 AI NO	i Li ies	2 L NO
n ot Vi	ding Physi h. After this c funeral din	cate: To	1 Yes 2 No	1 Inpatient 28a. Date of injury (Month, Day, Yo	2 ER/Outpatien 28b. Time of injury	28c. Inj	4 ☐ Nursing	Home 5 Resi	dence 6 Other		
VISIO	of ter deal	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S				28f. Location (: City or Tov	Street and Number vn, State)	er or Rural	Route Number,
	ne Hospita n 24 hours ne Funeral	Medical			nination and/or invest	igation, in my opi	nion, death occurred	at the time, date a	and place, and due	e to the cau	ise(s) and manner stated.
29b. Signature and title of certifier							006219	10	29d. Date signed	d (Month, E	Day, Year)
	•		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type, P	TINE HO	ERMAN H	NY,SUITE	A, CHESA	PEAK	ECITY, MD
	Sta Registra		31. Date filed (Month; Day, Year)	32. Palamer's	Signature .	ares					21915

11-05107 Madison Evelyn Riggie Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 | |

J P	0			Diac	R IIIu	CHAIC	IIIIK.	LIIQUI	e VII	COP	G3 F	716
Sta	ite d	of N	/larylar	nd / E)epart	ment	of He	alth an	d Me	ntal F	lygie	ene

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	_ (_ <	. 4	. •

		1- For State Registrar	Cer	tificate of	Death			Reg	. No.	
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)					N N	Date of Death	Day Yea	3. Time of Death
	ner	Madison Evelyn R 4a. Facility Name (if not institution, give			b. City, Town, o	and anotion		uly 8, 2011	4c. County of	2135 nrs
Đ		Rt. 40 & Johnny Cake Road		"	Westview	or Location	or Death			e County
Funeral		Social Security Number	7. Age (In yrs. la	st birthday)	If Under 1 Ye	ar If Unde	er 24Hrs. 8.	Date of Birth		9. Birthplace (State or
Director		219-47-6282 ₁	1 2×F 14	Yrs.	Months Da	ys Hours		ept 20	•	Foreign Country) MD
A		Usual Residence of Decedent								· · · · · · · · · · · · · · · · · · ·
м апу		10a. State 10b. County MD Baltimore		Town or Location						10d. Inside City Limits
yland -f she	to		Cat	onsvil						1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 6163 Northdale Re	oad		10f. Zip Code 2	1228			. Citizen of Wh USA	nat Country?
vith th			2. Was Decedent Ever in U.S	13 W/as	Decedent of H		nin? / Specific			- American Indian, Black,
eath v	uneral	1 Never Married 2 Married	Armed Forces?		s, specify Cuba				White	
after d	ш	3 Widowed 4 Divorced If		1 🔲	Yes 2 X N	o s <i>pecify:</i>			Specify:	White
nours a	þ€	15. Decedent's Education (Specify only	highest grade completed)	16a. Decedent	s Usual Occupa	ation (Give I	kind of work	done 1	6b. Kind of Bus	siness/Industry
36 n 72 h	Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+)		ident	e. DO NOT	use retired)		n/a	
withi giene.	E	17. Father's Name (First, Middle, Last)			luent	40.14-41-4	- Name (Final			
e filed al Hy ed of the	BeC	David William Ri	raie					Frazi	iden Surname)	
212 Duild b I Memi	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Stre					n, State, Zip Code)
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica		Brenda Riggie Mo	other							21228
re, s l and f Heal f'iten		20a. Method of Disposition 1 Burial 2 X Cremation 3		ace of Dispositi		emetery,	Dat	е 2	20c. Location -	City or Town, State
Baltimore, permit. Pages 1 ar Department of Hes Important: Uite		Donation 5 Other Specify:	removariioni state	antic (ry	7/12/	2011	Glen Bu	urnie, MD
alti epartn jury o		21. Signature of Funeral Service Licenses					Sterl			
	11630 Edmondson Avenue; Catonsville,								e, MD 21228	
Physician //Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Examiner										Death
		Sequentially list conditions, b	to (or as a consequence or).							
	ner	if any, leading to immediate Ducause. Enter Underlying Cause	to (or as a consequence of):				-			
	Examine	(Disease or injury that initiated C	to (or as a consequence of):							
1760, ficate be executed 3 physician and the burial - transit		d								
760, cate be executed physician and the bunal - transi	/Medical	UNPENDED A	MENDED							
Box 68760, e death certificate be the attending physic ad for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	-					23d. Date of c	•
ox 68 eath certif	ciar	past 12 months?	1Live birth 1 Pregnant at time of deat	h ====================================	death 3 r (Specify)	Ectopic	pregnancy		Month	Day Year
BOy e death the att	Physician	1 Yes 2 No 9 V Unknown	Unknown	□ Otne	(Specify)					
s, P.O. Be ires that the de signed by the	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the und	derlying cause o	given in Par	ti. 2	_		oute to the cause of death?
S, P uires t n sign id be c	bg b						— L	1 Yes :	2 ✓ No 3 L	Probably 4 Unknown
ords, w requir	Completed							24a. Was an autopsy	pr	ere autopsy findings available for to completion of cause of
Record The language 2	ĕ							performe ✓ Yes 2		eath? ✓ Yes 2 No
Vital Rec	Be	25. Was case referred to medical examiner?	4-1				Check only o			
f Vir	의	1 ✓ Yes 2 No Prost		R/Outpatient					sidence 6 🗸	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	<u></u>	1 Natural 5 Pending	(Month Day Year)	8b. Time of Inju 2134 hrs		ryatWork? Yes 2 ✔ I	Subi		injury occurred trian struck	
isio Atter er dear rector by th	g	2 Accident Investigation	28e. Place of Injury - At hom	e farm street				ocation (Stre	et and Number	r or Rural Route Number, City
Division pital or Attent ours after death teral Directors filled in by the	Certification:	3 Suicide 6 Could not be determined	(Specify) Major Road /			anang, oto.		r Town State	1	Westview, MD
Hosp 24 hou Fune rtely fi		20a Cartifies	To the best of my knowledge,		at the time, da	ate and place				
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medicai Examiner: On	the basis of examination and	or investigation	, in my opinion	, death occ	urred at the ti	ime, date and	place, and du	e to the cause(s)
	Σ	29b. Signature and title of certifier	1/1 VA		29c. Licens	e number		29	d. Date signed	(Month, Day, Year)
		Melin Bras	III MIS		O.C.1	M.E.		J	uly 9, 2011	
· /		30. Name and address of person who com	•	,						·
		/	stant Medical Examine		altimore S	treet, Ba	itimore, M	D 21223		
Sta Registr	te ,	31. Date filed (Man 2011 Year)	32. Registrar's Apparunt							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 22226 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JulyJames William Sumstine 20T1 7:22 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday, 8. Date of Birth 1 X M 2 □ F 19<u>43</u> July 15, **Director** Maryland 217-36-8951 67 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Examiner must be notified Waldorf 1 Yes 2 No MD Prince Georges 0 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a 2525 Lisa Dr. 20601 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 0, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No white 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than uth and Mental Hygiene. 27 is marked other than r traumatic event, the Mo Elementary/Seconday (0-12) College (1-4 or 5+) deliveryman autoparts store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Sumstine Ruth Rabbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Nancy Shockey - sister 407A Otts Shoals Rd; Roeduck, SC 29376 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Signature of Frier Service Livensee Naylør 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner ronar Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last this certificate has been signed by the attending physician a ral director, page 2 should be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Day Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Pesidence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the I within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signatura and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 23a per doc g917 7-13-11 vt. State of Maryland / Department of Health and Mental Hygien 20 | | for State Registrar Certificate of Death Rea. No 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:40 M 000 Medical Facility Name (if not institution, give street and number) 4b. City, Town 4c/County of Death Examiner 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (ear) Country) 8 6 1925 Director MD 219-18-4787 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f shorements the most be notified at Director 1 Yes 2 □ No BALTIMORE RANDALLSTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 5107 OLD COURT RD. 21133 items ? and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status traumatic event, the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK "natural" Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) BUILDING INSPECTOR HOUSING AUTHORITY 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MILTON H. THOMAS BESSIE DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains AMELIA DR. FT. OGLETHORPE, GA RUBY FEABRY/DAUGHTER <u> 30742</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1; cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VET.CEM. 7-15-2011 CROWNSVILLE, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Atherosclerotic ardiovascular Disease** Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has death? this certificate Yes 2 No 1 Yes 2 No • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certific 25. Was case referred to medica Trock director, 26. Place of Death (Check only one) Be examiner? è Hospital Other: 1 🗌 Yes 200 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) f death (Item 23a) (Type, Print) Name and addre who completed ar's Signature State Registrar

11-05148 Robert Watkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

bert Watkins		amend 15tate of Maryland 15epartment of 1-For State Registrar Certificate of		Reg. No. 2011				
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Robert Watkins		Month Day Year July 10, 2011	3. Time of Death 1241 hrs			
		4a. Facility Name (if not institution, give street end number)	4b. City, Town, or Location of Death					
		Johns Hopkins Hospital	Baltimore	N/A				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	Foreign				
Birector		216-92-0007 1\(\bigmu \) 2 F 35 Yr Usual Residence of Decedent	s.	2/17/1976 Cou	intry) Md			
any		10a. State 10b. County 10c. City, Town or Local	tion		10d. Inside City Limits			
	r	Md. N/A Baltimo	ore		1XX Yes 2 No			
with the Maryland ms 23a or 28a-f sho be notified at once.	Funeral Director	10e. Street end Number	10f. Zip Code	10g. Citizen of What Coun	try?			
the Name	힏	1656 Darley Avenue	21213	USA				
h with	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - Americ	an Indian, Black,			
or deal	Fur	1 Yes 2 X No	Yes 21 No specify:		1 1-			
ırs aftı ural" minel	ð	or Dates:	nt's Usual Occupation (Give kind of w		lack			
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during r	nost of working life. DO NOT use reti		,			
036 ithin	ш		d Jobs	Self Emplo	oyed			
15-003(filed within Hygiene. d other tha		17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surname)				
សិទ្ធិខ្លុំ ៩ Robert Lee Watkins Linda Hawkins								
shoul and N is in maric	٦			t, Baltimore, Mo				
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Impurtant: If item 27 is ma injury ar ather traumatic er		20a Method of Disposition 20b Place of Dispo	sition (Name of cemetery	Date 20c Location - City or T	Town State			
JOF ages 1 nt of F t: If i		1 X Durial 2XX Cremation 3 Removal from State tro Crematory or of Crematory of the Cremator	ther place) 7/1:	8/2011 Catonsville 9/2011 Baltimore	e, MD			
lit. Partmer artmer artmer artmer artmr	- 8		Name and Address of Facility	5/2011 partimore	9, M- et.			
De De de de de la company de l	- 1/	Lloyd mater	Estep Brothers	Funeral Service	e, PA Md. 21217			
Physician		23a. Part I. Enter the disease, or complications II at caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease a Complications of G	Sunshot Wound		Death			
		or condition resulting in death) Due to (or as a consequence of):						
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	miner	cause. Enter Underlying Cause (Disease or injury that initiated						
led nsit	Exa	events resulting in death) Last Due to (or as a consequence of):			E 19			
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e be ysici	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	per me g/20 10 3	23d. Date of delivery				
Box 68760, cath certificate be the attending physici at for use as the buning b	an/M	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregna		ay Year			
OX eath c atten for us	hysici	1 Yes 2 No 9 Unknown 9 Unknown	ther (Specify)					
the d	된	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the	ne cause of death?			
ires that the signed by the detac	ğ			1 Yes 2 No 3 Proba	ably 4 🗹 Unknown			
rds, requir	Completed	_			opsy findings available ompletion of cause of			
CO le law le has ge 2 sl				autopsy prior to co performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	·			
of Vital Records, of Physician: The law require the this certificate has been si meral director, page 2 should t		25. Was case referred to medical	26.Place of Death (Check of		2 110			
Vita ysicia ysicia his cer direct	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien	IOther —	g Home 5 Residence 6 Other:				
		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of	Injury 28c. Injury at Work?	28d. Describe how injury occurred				
No subject shot Section Street Corper S								
ivision or Atten after death Director: I in by the	Natural Natural Natural Natural Note of the pending Investigation Suicide Natural Natural Natural Note of the pending Investigation Suicide Note of the pending Investigation Note of the pending I							
file on	Se	4 X Homicide determined (Specify) street	corner	and Charles St. Ba				
To the Hospital within 24 hours Tn the Funeral completely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence) 2 Medical Examiner: On the basis of examination and/or investigation.	rred at the time, date and place, and tion, in my opinion, death occurred at	due to the cause(s) and manner as stated the time, date and place, and due to the	d. cause(s)			
To the within Tn the comple	Medical	2 Medical Examiner: On the basis of examination alturor investigation and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont				
		M M	O.C.M.E.	July 11, 2011	, 20,, 1001)			
pend		30 Name and address of pages who sampleted as a contribution of		1 00.7 17, 2071				
Y-	- 1	 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 	W Politimoro Stroot Politim	MD 04000				
7.0	- 4	Doma W. Vincenti, MD Assistant Medical Examiner 300	vv. Daitimore Street, Daitim	iore, MD 21223				

OCME

			1 - State of Mar Registrar	•	epartment of Certificate of		l Mental Hy	rgiene Reg. N2011	22229
	Physicia	an/	1. Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death
der.	Medi	cal	ANNA FLORENCE WILLIAMS 4a. Facility Name (if not institution, give street and number)				July	10, 301	
	Examir	ner	Franklin Square Hospital Clar	م ما	Ab. City, Town,	or Location of Dea	ath	4c. County of Dea	
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	170000	If Under 24 Hr		th 9. Bir	rthplace (State or Foreign
	Director	ļ	220~50~4634	2 Y	's.	Tiodis Will	July 7	,1919	Iowa
	and show	ē		10c. City, Town o	or Location		-		10d. Inside City Limits
	Maryl 28a-f otified	irect	Maryland Baltimore		Baltimo	re Count	у		1 🗌 Yes 2 🛛 No
	ith the 23a or it be n	Funeral Director	10e. Street and Number 4248 Cardwell Avenue		10f. Zip Code	21236		10g. Citizen of What Co	ountry?
	eath w	-une	11. Marital Status 12. Was Decedent Eve	er in U.S.	13. Was Decedent of I		Specify Yes or No-		erican Indian.
36	ifter d ", or if amine		1 ☐ Never Married 2 ☐ Married 3 ★★ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes ② Not If Yes, Give Year or Dates.	0	If Yes, specify Cub		erto Rican, etc.)	Black, Whit	
Ö	atural	Completed by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates. 15. Decedent's Education		ecedent's Usual Occu				
215	n 72 h e. ian "ni Medi	lduu	(Specify only highest grade completed)	(0	Give kind of work done fe. DO NOT use retired	during most of w	orking	16b. Kind of Business	Industry
Anna and 212	d withi lygiene ther th	Be Co	12 yrs. N/A	Ho	usewife			<u>'</u>	ng-Own Home
/ F	d be filed Mental H arked of	To B	17. Father's Name (First, Middle, Last) Jacob Hawk				_{ame (First, Middle,} e Julia I	, Maiden Surname) Brown	
પગો[!હત્માર્ગ , Anna Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Richard L. Williams (Son)		Mailing Address (Street 313 Cosner			er, City or Town, State, Zi	_
See,	t of He If item or othe	. 1	20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State	cemetery,	Disposition (Name of crematory or other pla	ice)	Date	20c. Location - City or	
<u> </u>	urtmen urtmen ortant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. 91: ab re of Funeral Service (Ocensee	Gardens	of Faith		3~2011	Baltimore	, Md.
Ba	Department of the service of the ser		21. Mattre of Pulifical Service Liberisee	\mathcal{I}	7401 Bela	air Rd.	ssahn Fu Baltimor	neral Home e, Md. 2123	6
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ie death. De not	enter the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between
	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Ar + Property of the condition and the condition are sufficiently and the condition are sufficiently and the condition are sufficiently as a condition are	nycco	idial infi	arction			Onset and Death
	Examiner			ons ruence on					
\ \ .	ad sit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	onsequence of)					
W	execute in and ial-tran	Exal	that initiated events resulting in death) Last C Due to (or as a co	onsequence of)					
09	ate be executed bhysician and the burial-transit	dical	d						
687	certificate inding physuse as the	/Me	IF FEMALE: 23c. If ves. outcome of	pregnancy					
Box 687	requires that the death certifica been signed by the attending p should be detached for use as t	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 23c. If yes, outcome of 1 Live Birth 2 Pregnant at til		3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date of de Month	Blivery Day Year
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pro	aw requas been 2 shou	plete	Congestive heart failure				24a. Was	an 24b. Were au	utopsy findings available
Rec	ician: The law certificate has rector, page 2.9	Com					- auto perfo	ormed? death?	completion of cause of
tal	ician: sertific ector,	Be	25. Was case referred to medical examiner?			Place of Death (Ch			
Ž	Phys r this eral dir	2	1 Inpatient 27. Manner of Death 28a. Date of injury	28b. Tim	atient 3 DOA Oth	4 ☐ Nursing	1	dence 6 Other (Spec	cify)
ouo	ending sath. or: Afte	ficate	1 X Natural 5 ☐ Pending (Month, Day, Y 2 ☐ Accident _ Investigation	<i>'ear)</i> inju	ry wor	k? Yes 2 ☐ No	200. Describe i	low injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (5	- At home, farm Specify)	, street, factory, office		28f. Location (City or Tov	Street and Number or Ru vn, State)	ral Route Number,
	To the Hospita within 24 hours To the Funeral completed filled	Medical (29a. Certifier 1 ertifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam						
	o the hithin 2, the Formplet		only one) 3 Certifying Nurse Practioner To the bes	st of my knowled	ge, death occurred at the	ne time, date and p	place, and due to th	ne cause(s) and manner as	s stated.
	¥ ¥ ك		David Hum	es t		0536°	94	29d. Date signed (Mont	i, Jay, rear)
	10		30. Name and address of person who completed cause of deat		oe, Print)			/ / /	
	P		Doniel Shinners, M.D. 90 31. Date files Montin By 2011	too for	Kklin Squ	sare Dr	Baltim	icre, MD	21237
	Stat Registra		JUL 13 ZUII	olgilati e					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #9,11,12,15,16a&B,17,18b,19b, Per ANA BD C917,7/14/2011 JH

1- State Amend Item 25 per me,g917,07/29/2011dhb,
Registrar Reg 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Honth Y 9:39 Jessie Walker Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ttospital Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛛 F Days Hours Min. 0c(Month, Day,1 928 82 Director 416-88-1454 Alabama Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 2 Poolside Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status -unk 14. Race - American Indian, Black, White, etc ģ 1XXNever Married 2 Married black 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 | Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic events". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled +mkBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ၉ Rosie Lee Walker Jessie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Sandi Cooks - daughter Poolside CT. Catonsville,MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) in State 22. Name and Address of Facility State Anatomy Board 21. Signature of F. neral Service icensee Dariel/ A. Na 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) SUMINOS Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DETIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) signed by the attending physician and a be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETTS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPER TENSION 24a. Was an has performed 2 🗌 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident 🔲 Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

The law requires that the death certificate be Records, Division of Vital the Hospital or Attending Physician: Walker

Box 68760

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Director: After this certificate Certificate: within 24 hours at

To the Funeral D

completed filled in 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, diseth occurred at the time, date and place, and die to the ceres(s) and manner as state 29b. Signature and title of certifier 00051865

29d. Date signed (Month, Day, Year) JULY 6, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS CHARLES

SI AGNES HUSPITAL 900 CATON AVE, BACTMORE

MI)

State Registrar

31. Date filed (Month, Day, Year) -- -

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 22231 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 11, 2011 Year 5:00 a M JOHN J. WALL SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE 629 FAGLEY STREET Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Davs Hours NOV. Day Year) 1925 ^CMARYLAND 220-14-3696 85 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 X Yes 2 ☐ No BALTIMORE MD N/A 10e. Street and Number 10g. Citizen of What Country? ō other traumatic event, the Medical Examiner must be Funeral 23a U.S.A. 21224 629 FAGLEY STREET items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE and Mental Hygiene. is marked other than "natural", 3 X Widowed 4 ☐ Divorced Year or Dates.1943-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE CITY 10 **MAINTENANCE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည IRENE COUGHLAN JOHN SHERIDAN WALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is FAGLEY STREET, BALTIMORE, MD PATRICIA WALL/ DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 XBurial 2 Cremation 3 Removal from State OAK LAWN CEMETERY 7/15/11 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) Name and Address of Eacility ERGINC FUNERAL HOME 700 S. CONKLING STREET, BALTO, MD Signature of Funeral Service Licensee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final as un Physician/ 5 6 disease or condition resulting in death) MUS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NR 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been sign 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🔽 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Qutpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one 29b. Signature and time of certifier 29d. Date signed (Month, Day, Year) 1-2011 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2801 Hudson swell w. macoona CIM 31. Date filed (Month, Day, Year) State 1 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month WI<u>LLIAM EUGENE ASMUSSEN</u> JULY 2011 40P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. WASHINGTON ADVENTIST HOSP TAKOMA PARK If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8 Date of Righ 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Days Hours 1 🕅 M 2 🗆 F MD . 1 - 2 4 - 1 9 4 2 68 Director 218-74-2967 Usual Residence of Decedent ıra!", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. PRINCE GEORGES HYATTSVILLE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5902 QUEENS CHAPEL ROAD 20782 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Completed by ☐ Yes **X**☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify:WHITE "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) DISABLED NONE 3rd Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHANN CHRISTIAN ASMUSSEN pe t NETTIE CURTIN should 19a. Informant's Name/Relationship (Type, Print) .. Page 1 and 2 shou tment of Health and tant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LETCHER ROAD BRANDYWINE, MD. 20613 DORIS HALL-NIECE permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date TRINITY MEM. GARDENS 7-8-11 ■ Burial 2 □ Cremation 3 □ Removal from State WALDORF, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service License M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ARRYTAMIA Physician/ disease or condition Medical resulting in death) Examiner ANOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine CORONAR attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year 1 Yes 2 L 9 Unknown Yes 2 No signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed 1 ☐ Yes 2 🗷 No re Hospital or Attending Physician: The n 24 hours after death.

For Funeral Director: After this certificat pleted filled in by the funeral director, px 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 100 Other: ျ 1 Thipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier -59284 04/2011 HAMIM, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAWIW, WASHINGTON ABVONTIST HOSE, TAKOMA PARK SHAMIM, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tems 1/818 per FH G917 // 13/11 dk State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> July Physician/ Year $_{\mathtt{A}}^{\mathtt{M}}$ Eleanor Elaine Almony 4 4:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 162 McIntosh Drive Colora Cecil 8. Date of Birth (Month, Day, Year) June 12, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗆 M 2 🕱 F Director 219-22-1044 84 Yrs. 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ems 23a or 28a-f sh must be notified a 1X Yes 2 ☐ No MD Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 162 McIntosh Drive 21917 U.S.A. ural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 🛮 Widowed 4 🗆 Divorced Specify. Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Secretary Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Milford-H.--Thompson Milton H Thompson Onieda-Robinson Oneita Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl E. Joyner/Daughter 162 McIntosh Dr. Colora, 21917 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jul∜ Ayres Chapel Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 White Hall, MD . Signature of Juneral Syrince Licensee 22. Name and Address of Facility JJ Hartenstein Mortuary, 19 S. Main St. Stewartstown, PA 17363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Jementia disease or condition PRING Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) Physician; The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by STENDSIS 1 Tes 2 No 3 Probably 4 Unknown Condiany opath Congestive Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed?

Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending М 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12002835 03/02/ Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21911 W.D sun. 101 COLOMAL 31. Date filed (Month. Day. 32. Registra s Signature State Registrar

The

State Registrar Cambridge MD 21613

Name and ddre's of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

/ Vorum/to

31. Date filed (Month, Day, Year)

JUL 1 3 2011

	For AMEND#2, 29d per PHYState of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 6/23/2011 AACO HEALTH DEPT. CMH Certificate of Death Reg. N. 2												
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates.	lo		Yes, specify Cub	an, Mexican, Puerto Specify:	o Hican, etc.)		Black, W Specify: W		
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Baltimore,	permit Depart Impor any in		21. Signature Funeral S. vic. Icen	Withan	le	^{22.} 29	Name and Address 73 Solor	^{ess of Facility} Ge nons Isla	orge P. nd Rd.,	Kala Edg	as Fun ewater	era , M	1 Home D 21037
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ב	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. completed birector. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin										e(s) and manner stated.
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~			30. Name and address of person who co	mpleted cause of dea	ath (Item 23	a) (Type, Pr	int)				مرر)	
3	UL		KHAWAJA-A-	FAROO	6,0	100	Medic	I Park	way, An	MP	ofis,	N	1D 21401
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ June 25 ay 20 1°1 11:35 PM Hilda Aaronson Aks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emeritus of Potomac Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day,) Months Days Hours Min Director 217-03-9614 92 1918 Maryland Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. 25 so marked than "hatural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at the traumatic event, the Medical Examiner must be notified at 10a. State 10b. County irector 10c. City. Town or Location 10d. Inside City Limits t XYes 2 ☐ No MD Montgomery Potomac ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA Fallsmead Way 1917 S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedo... Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Sales Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Louis Aaronson Esther Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leland M. Aks - Son 1917 Fallsmead Way, Potomac, Maryland 20854 other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemeters crempton of other place)
Memorial Gardens 1 X Burial 2 Cremation 3 K Removal from State 6/28/2011 4 Donation 5 Other (Specify) Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facilited ward Sagel Funeral Direction, Inc. magreenal mo 1597 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer of the Bladder Onset and Death Ph_sician/ disease or condition , Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) than, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-racsit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Depression 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) ompleted filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Benny a. Heckmand

Canecan

JUN 2 8 2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silver

Spena

32. Registrar's Signature

00005373

Ronal

Bernard A. Heckman,

June 27, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Delcie Mae Blizzard 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner All**egany Cumberland Medical Center <u>WM Regional</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2**x**□ F 234-38-7951 12/10 85 Director aska Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Allegany Westernport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21562 21207 Queenspoint Rd., SW USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3X☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Retail Sales Retail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruby Keplinger Clarenece Veach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1454 Winged Foot Ct., Murrells Inlet, SC 29576 Arbutus Heishman/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Potomac Memorial | 7/9/2011 Keyser, WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. Box 912, Keyser, W 26726 P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading term list cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the burial-transit and resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Month Day Year 1 Yes 2 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Napatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 1 Yes 2 No Accident Investigation

(0 gm

State

Registrar

Medical

6 Could not be

determined

and address of person who completed cause of death (Item 23a) (Type, Print)

Suicide

Date filed (Month, Day,

1 3 2011

4 - Homicide

29a. Certifier (Check

only q

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2501

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0018216

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Willowbroke Rd

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Harry James Burdette, Sr. 2011 July Medical 5:46 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 121 West 5th Street Frederick Frederick If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Mary Land Min Months Days Hours (Month, Day, Year) 01/18/1944 Director 214-42-1073 67 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Frederick 1 Yes 2 No Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 121 West 5th Street 21701 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 <u>Grocery Stocker</u> Grocery Store traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ John Burdette Frances Renner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mabel Burdette / wife 121 W. 5th Street, Frederick, Md 21701 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 07/11/2011 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 E. Church Street, Frederick, MD 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Concestive Heart Failure Medical resulting in death) **Examiner** Ischemic Cardiomyopathy Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ending physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Petal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year ed by the a detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension has autopsy performed? this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🏋 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License numbe 29d. Date signed (Month, Day, Year) 07/06/2011 D 27544

Hay

State Registrar Dr. John A. Vitarello / 180 TJ Drive, Suite 202, Frederick, MD 21702

ate filed (Month, Day, Year)

32. Registrar's Signature

32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		State of Maryland / Depa	artment of Health and Me		Legible.
	•		tificate of Death	Reg. No	011 22239
Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death
Medic	al	Geneva Mae Buckler 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	une 20, 20	11 2:30 A M
Examin	er	Civista Hospital	LaPlata		Charles
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth	9. Birthplace (State or Foreign Country) 921West Virginia
Director		577-20-5014		ept. 29, 1	
yland -f sho	ctor	10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1X Yes 2 □ No
he Mai or 28a s notifi	Dire	Maryland Prince Georges Capitol 10e. Street and Number	Heights 10f. Zip Code	10g. Citiz	zen of What Country?
s 23a onst be	Funeral Director	1713 Eden Avenue	20743	USA	·
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rs after rral", o Exam	ed by	3 X Widowed 4 □ Divorced 1 □ Yes 2 No If Yes, Give 1 Year or Dates.	1 ☐ Yes 2 🛣 No Specify:	S	Specify: White
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d 2 sho alth an 27 is er trau		Tob. Main	Valley Drive, Wald		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Dispo cemetery, cren 20a. Method of Disposition 20b. Place of Dispo cemetery, cren	natory or other place)		cation - City or Town, State
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Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FB/Outpatient	26. Place of Death (Check or		
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al or As s after I Direc	-	4 Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	et, factory, office	City or Town, State)	Number or Rural Route Number,
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To the within To the compl	Ž	only one) 3 Certifying Nurse Practioner. To the best of my knowledge, of 29b. Signature and title of certifier	29c. License number	29d. Date	e signed (Month, Day, Year)
) Ufface	1)22574	mo	6/22/11
286		30. Name and address of person who completed cause of death (Item 23a) (Type, F Robert + PACC mp / Z070 OC	D LINE CTR. +	#302WA	WORF MDZ0602
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5		Am	Please Type o ended Item 7 per F.D 066	r Print in Black Ir 13/11 Carroll of Maryland / Depa	delible In County, artment of I	k. Ensure Al Wjl Health and M	I Copies ental Hyd	Are Legible	
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	Funeral Director		5. Social Security Number 6. Sex 201-24-2969 1 MM 2 F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign untry) Svlvania
	and show dat	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	or 28a-f	Direct	PA Lancaster Cour	nty Lititz	10f. Zip Code			0g. Citizen of What Co	1 🗆 Yes 2 🔀 No
	th with the ms 23a comust be	Funeral Director	317 East Woods Drive		17543			Jnited Stat	
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.	þ	1 Never Married 2 X Married 1 X Yes	orces?	Vas Decedent of History (1985) Yes, specify Cuba Yes 2 X No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: W	
21215-0036	ithin 72 hou ene. • than "natu he Medica	Completed	15. Decedent's Education (Specify only highest grade complete	d) 16a. Deced (Give k	lent's Usual Occup kind of work done O NOT use retired) & die ma	during most of working	9	16b. Kind of Business	Industry
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Baltimore,			20a. Method of Disposition 1 🐰 Burial 2 □ Cremation 3 🗶 Removal from 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispose cemetery, crem Longeneck Cemetery	sition (Name of patory or other placer Breth	ren June	4 4	20c. Location - City or Lititz, PA	
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200			resulting in death) Last Due to	(or as a consequence of):					
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Division of Vital Records,	to the hospital or Attending Physician: To the Funeral Director. After this certific completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	e of Injury - At home, farm, streeting, etc. (Specify)	et, factory, office	28	lf. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	ne Hospi in 24 hou ne Funer pleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base of the ba	sis of examination and/or investig	gation, in my opinic	n, death occurred at th	e time, date and	place, and due to the o	ause(s) and manner stated.
	Mith Som With		29b. Signature and title of certifier ▶ 7 Babelle Tac G		29c. License	number	29	d. Date signed (Month	, Day, Year)
	12+1VA		30. Name and address of person who completed cau N. ISABELLE TACGRES	se of death (Item 23a) (Type, Pr	int) -OK STR	EET, BA		-	
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			1 - State of Ma	aryland / Depa <i>Cer</i>	artment of H tificate of D			giene Reg. N	11 2	2241
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th		Time of Death
	Physicia Medio		Ernest Daniel Bran	nson			June 2	6, Day 201	1 Year 3	:50A M_
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County			
			Casey House/Montgomery Hos 5. Social Security Number 6. Sex 7. Age		Rockv If Under 1 Year				gomery	
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	with s 23a ust b	Funeral	4900 Damascus Road		20882			ι	J.S.A.	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 M Married 12. Was Decedent E-Armed Forces? 1 N Never Married 2 M Married 13. Widowed 4 Divorced	No II	Was Decedent of Hi f Yes, specify Cubar ☐ Yes 2 👿 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Blac	ce - American Ind ck, White, etc. White	ian,
8	ours atura cal E	etec	3 ☐ Widowed 4 ☐ Divorced Year or Dates. ▼		lent's Usual Occupa	ation			usiness Industry	
Maryland 21215-0036	n 72 h a. an "n Medi	Completed by	(Specify only highest grade completed)	(Give F	kind of work done d O NOT use retired)	luring most of work	ing	100. KING OLB	usiness industry	
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and	e filed ntal Hi ed otl even	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			e)	
₹ Z	uld b d Mer mark natic	-	Frederick Branson 19a. Informant's Name/Relationship (Type, Print)					ynes		
Ma	2 sho th an 27 is i	8	Charlotte R. Branson - Wife		ng Address (Street a Damascus					20882
	f Heal item	1	20a. Method of Disposition	20b. Place of Dispos	sition (Name of	-	Date		- City or Town, St	
altimore,	0 4- 1-		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Gate of B	natory or other place Heaven	· !	1. 2011			g, Maryla
Balti	permit. Page Department Important: I any injury or		21. Signature of Fun ral Service Libensee) 22 Mo	Name and Addres olesworth 6401 Ridg	s of Facility -Williams	s P.A.,	Funera1	Home	0872
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.						Appro	oximate val Between
~-]	Ph _y sician/		Immediate Cause (Final	er Cancer						t and Death
	Medical Examiner			consequence of):						
		er	Sequentially list conditions, b.							
	ed nsit	Examiner	if any, leading to immediate Due to (or as a cause. Enter Underlying Cause (Disease or impry	consequence of):						
	xecut n and al-tra	Exa	that initiated events c.	consequence of):						
09	ate be executed physician and the burial-transit	dical I	d							
6876	tificat ng ph as th	Mec	IF FEMALE:						<u> </u>	
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23h Was decedent program 23c. If yes, outcome c	Petal death 3	Ectopic pregnancy Other (specify)	у			te of delivery onth Day	Year
0	that th	by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	pacco use cont	ribute to the caus	se of death?
ds,	quires en sign	ted b					1 🗆 Y	es 2 🗆 No	3 Probably	4X Unknown
Division of Vital Records,	he law reite has be age 2 sho	Completed					24a. Was a autops perform	med?	Were autopsy find prior to completion death?	on of cause of
a	sian:] ertifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Check		ALA NO	1 163 2 1	40
Ξ	hysic this ce	욘	1 ☐ Yes 2 🛣No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien		4 ☐ Nursing Ho	me 5 Reside	ence 6X Othe	er (Specify) H	ospice
0	ding P n. After t funera	Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of injung (Month, Day,		28c. Injury work?	?	28d. Describe ho	w injury occurr	ed	
SIO	Atten deat ctor, y the	rii	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injur	y - At home, farm, stre		Yes 2 No	28f Location (St	reet and Numbe	er or Rural Route	Number
\leq	al or A s after Il Dire ed in b		4 ☐ Homicide determined 256. Place of injur building, etc.		,,		City or Town		er of Flarar Floate	rvarnoei,
	Hospit 24 hour Funera eted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of example 1 Medical Examiner: On the basis of example 2 Medical Examiner: On the basis of example 2 Medical Examiner: On the basis of example 2 Medical Ex	amination and/or investi	igation, in my opinior	n, death occurred at	the time, date an	d place, and due	e to the cause(s) a	and manner stated.
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practioner: To the b	est of my knowledge, d	leath occurred at the 29c. License				anner as stated. d (Month, Day, Ye	ear)
			Natorah Mille	U CRN	P R14	3201		6/2	26/11	
a	+ 1 14		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, P	rint)		1 4 = =	7	1 000	
7	Stat		31 Date filed (Month, Day, Year) 32 Registrar	1 Muncaste	,	oad, Roc	kville,	Maryla	ind 208!))
	Registra	ir	JUN 27 2011 Sense	n p. 19	arke					4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June Physician/ Zor/ 2855PM oretta Theresa Bradley. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎗 F Months Days Hours Min. (Month, Day, Ye 1922 Pennsylvania 89 198-12-7404 Jan. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1X Yes 2 No Maryland Prince Goerge's Bowie Baltimore, Maryland 21215-0036 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20715 USA 12214 Rockledge Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Megorea. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Doctor's Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Esther Coonan Vincent Flannery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12214 Rockledge Drive Bowie, MD 20715 Sue C. Bradley/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Lakemont
morial Gardens 6/30/2011 |Davidsonville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Pregnant at time of death should be detached 9 Unknown a 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No death? 1 Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: s after death. 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D61552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118Good Lucked, Lockam, MD, 20706

DHMH 17 Rev 7/2009

State Registrar Ke

VIN 31. Date filed (Month)

fan, MD.

32. Registrar's Signature

11-04969 Chase Edward Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # State of Maryland Department of Health and Mental Hygiene 20 | 22243

		1- For State Registrar	Certificate of	of Death	Reg.	No.	
Physic	ian/	Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death
Medical Exam	iner	Chace Edward Brown	July 3, 2011		1008 hrs		
		4a. Facility Name (if not institution, give street and nur		4b. City, Town, or Location of Deat Glen Burnie	h	4c. County of Death Anne Arundel	
		Baltimore Washington Medical Center			n 19 Date of Birth	(MM/DD/YYYY) 9. Birl	holace (State or
Funeral Director			7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Min rs. 21	_	Eorgia	
Director		235-57-0390 1XXM 2 F	Y	rs. 21	0/13/	2011 (8	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			10d, Inside City Limits
*		West VA Mineral	**	k Garden			1 Yes 🛠 No
faryland 28a-f sho	호	10e. Street and Number		10f. Zip Code	100	. Citizen of What Cour	itry?
e Mar or 28,	Director	P.O. Box 26 Center Street		26717		USA	,
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	멸			Vas Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ameri	can Indian, Black,
eath w	Funer	1XX Never Married 2 Married Armed Fo		Yes, specify Cuban, Mexican, Puerto		White, etc.	B1ack
her de l', or		3 Widowed 4 Divorced If Yes, Give Year	1 _	Yes 2 No specify:		Specify:	White
ours at	d b	15. Decedent's Education (Specify only highest grade		ent's Usual Occupation (Give kind of		6b. Kind of Business/I	ndustry
2 3 🚍	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+)	most of working life. DO NOT use re	(ired)		
5-0036 led within tygiene. other tha	ם	0		N/A		N/A	
5-0 led w Hygic		17. Father's Name (First, Middle, Last)		18.Mother's Nam	e (First, Middle, Ma	iden Surname)	
2121 Meld be fi Mental 1 marked c event,	BB	Melvin Brown Jr. 19a. Informant's Name/Relationship (Type, Print)	1	Amanda	Close		7: 0-1-)
MD 21215-0036 12 should be filed within 7 th and Mental Hygene. 127 is marked other than umatic event, the <u>Medica</u>	잍			ng Address (Street and Number or Box 26 Center S			
_ 2 = = =		Amanda Close Mother 20a. Method of Disposition		osition (Name of cemetery,		20c. Location - City or	
	Н	1XX Burial 2 Cremation 3 Removal fro					
Lim Pag ment tunt:	Ш	4 Donation 5 Other Specify:	Glen Hav	en Cemetery 7/	9/2010	Glen Burni	e, MD
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr	Ш	21. Signature of Funeral Service Licensee	22.	Name and Address of Facility Ha	rdesty Fu	neral Home	, P.A.
Physician		23a. Part I. E. or the disease, or amplications that ca	U.Z. used the death. Do not enter	Ridgely Ave. A	nnapolls, or respiratory arrest	MD Z1401 t, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.					Between Onset and Death
xaminer	8 8	Immediate Cause (Final disease or condition resulting in death) a.Sudden l Due to (or as a condition resulting in death)		eath in Infancy	(2001)		
		Sequentially list conditions, b	,				
	ner	if any, leading to immediate cause. Enter Underlying Cause	consequence of):				
	Examiner	(Disease or injury that initiated C.	consequence of):				
uted Id ansit	Ä	d.					
1760, ficate be executed 5 physician and the burial - transit	Medical	▼ UNPENDED ▼ AMENDED#	as noted,23a	,27,28a-f,per me	,g919 9−2	:6-11 sm	
760, ficate be g physici the buri	Mec		utcome of pregnancy		-	23d. Date of delivery	
687 Sertific Iding p	an/	23b. Was decedent pregnant in the past 12 months?	nt at time of death	etal death 3 Ectopic pregn	ancy	Month D	ay Year
Sath catter	Physician	1 Yes 2 No 9 Unknown 9 Unknown	٥_ (Other (Specify)			
that the de red by the detached it	된	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
P.O. res that the signed by be detac	þ				1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
of Vital Records, og Physician: The law require of the certificate has been si meral director, page 2 should b	Completed by				24a. Was an		topsy findings available
COT law r has b	힐			<u> </u>	autopsy	ed? death?	ompletion of cause of
tal Rec		OF Was area sets and to modical		26.Place of Death (Check	1 Yes 2	No 1 ✓ Ye	s 2 No
Vital F ysician: ' his certific director, j	Be	25. Was case referred to medical examiner? Hospital:	patient 2 🗸 ER/Outpatie			esidence 6 Other	:
of Vir g Physic fter this neral din	의	27. Manner of Death 28a. Date of	f Injury 28b. Time of		28d. Describe ho	w injury occurred	
C# 1 4 2	[윤	Natural 5 Pending fd 7-	Day, Year) 3-11 fd 9:0	0 am 1 Yes 2 X No	Unknown		
Division tal or Attendi rs after death. al Director:	E	2 Accident Investigation 3 Suicide 6 X Could not be	of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Str	eet and Number or Ru	ral Route Number, City
Division of 'pital or Attending Phous after death. teral Director: After tilled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specify)	found in	house	Glen Bur	⊝935 Lomba nie,Md.	rdee CIr.
Hos 24 h Fur		29a. Certifier Certifying Physician: To the best	of my knowledge, death occ	urred at the time, date and place, an	d due to the cause(s) and manner as state	ed.
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 (Check only 1) one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month)							
C N N S	ž	29b. Signature and title of certifier	11	29c, License number		29d. Date signed (Mo	nth, Day, Year)
		4 M	1	O.C.M.E.		July 4, 2011	
1, -		30. Name and address of person who completed cause		Deltinore Cheest Deltinore	MD 24222		
1/3				Baltimore Street, Baltimore	5, IVIU Z I ZZ3		
S Regis	tate trar		istrar's Signature	ake			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fh g917 7-19-11 vt
State of Maryland / Department of Health and Mental Hygiene 22244 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 Margaret Brown 10:30 AM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 7 Age (In vrs. last birthday) January (State of Foreign Country) 1927 South Carolina 1 □ M 2 👿 F Months Hours Min. 84 Director 250-46-6814 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 □ No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5210 N. Capitol St., NW #107 20011 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. à 1 X Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give 1951 Year or Dates. 1954 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.I once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Walter Reed Army Med College (1-4 or 5+) Elementary/Seconday (0-12) Medical Records Clerk Center Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rosa Lee Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913 24th Ave Hyattsville, Md 20783 Laura Hill / Friend 20a. Method of Disposition unk 20b. Place of Disposition (Name of unk cemetery, crematory or other place) Date unk 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National 7-11-11 Triangle, VA. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Dreta Mancis 3401 Bladensburg Rd Brentwood, Md 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death 20 Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ancreas ancer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the humant transit. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ₪ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nume Practiceer: To the best of my knowledge death occurred at the time, date and place and flue to the c 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 00060100 06-19-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA Hm I A University BLUD Eur 31 Silve Sport MO 31. Date filed (Month, Day, Year)
JUN 3 0 2011 State Registrar

For State Registrar

Dhysisis	· · · /	1. Decedent's Name (First, Middle, Last)						2. Date of De	_	/Year	3. Time of Death
Physicia Medic		Kathleen	June			une 27	27, 2011 Year 0235 A M				
Examin	er	4a. Facility Name (if not institution, give street	and number)		4b. City, Town				4c.	County of Dea	
		Holy Cross Hospit 5. Social Security Number 6. Sex		. last birthday)	S If Under 1 Ye		Sprin er 24 Hrs.		41-	Montg	
Funeral Director		1 □ M		Yrs.	Months Day			3. Date of Bir an • 25	y, Year) 9	24	irthplace (State o <i>r Foreigi</i> ^{ou} VTrg inia
		578-34-8452 Usual Residence of Decedent						<u> </u>	,		
land show	tor	10a. State 10b. County	10c. C	City, Town or Lo	cation						10d. Inside City Limits
Mary 28a-f otifie	Director	DC				W	ashing	ton			1 🔀 Yes 2 □ N
a or be no	G .	10e. Street and Number			10f. Zip Code	Э			10g. Cit	izen of What C	
h with	Funeral	2012 10th Street NV	J			20001	L			United	States
deat riten iner		A	as Decedent Ever in U med Forces?	J.S. 13. \	Was Decedent of f Yes, specify Cu	f Hispanic C Jban, Mexic	Origin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Am Black, Wh	
al", o	d by	o 🔀 west and a 🗆 Drivers of	☐ Yes 2 🎦 No Yes, Give ar or Dates.	1	Yes 2 🛚	No Specia	fy:			Specify: B	lack
natura ical E	Completed	15. Decedent's Education		16a, Deced	ient's Usual Occ	upation			16b Ki	nd of Busines	s Industry
n 72 l an "r Med	g E	(Specify only highest grade cor Elementary/Seconday (0-12)	npleted) allege (1-4 or 5+)	(Give	kind of work dor O NOT use retire	e during mo	ost of working	1	100.11	na or basinesi	o industry
withii giene er th , the		12th	niege (1-4 di 5+)		Nurs	ing				Priva	te
filed al Hy d oth) Be	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name (
Id be Ment arke	욘	Willie	Banks					Vinni	e Ho.	Lmes	
shou and is m		19a. Informant's Name/Relationship (Type, Pri	nt)	19b. Mailir	ng Address (Stre	et and Num					*
and 2 lealth		Shirley Ann Holmes - 20a. Method of Disposition			10th St	reet	NW Wa	shing			0001
ge 1 and the strategy of the s		1 A Burial 2 ☐ Cremation 3 ☐ Remo		Place of Dispo cemetery, cren	sition (Name of natory or other p	lace)	July Da	^{te} 5,	l .	cation - City o	
t. Pac rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify)		Harm			2	011			r, Maryland
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenties	to the		. Name and Add						
	Н	23 End . Enter the disease, or complicatio	- 11		001 Ben					on, DC	T
		shock, or heart failure. List only one cause Immediate Cause (Final	se on each line.	atti. Do not ente	a trie mode or d	ying, such a	is cardiac or i	espiratory ar	1651,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	espiratory		re						Onset and Death Weeks
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cate be executed physician and the burial-transit	Ë	that initiated events c. Due to (or as a consequence of):									
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tificat ng ph as th	ian/Medical	IF FEMALE:									
ath certi attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregr Live Birth 2 🗌 Fe	tal death 3	Ectopic pregna	ancy			- 41	23d. Date of d	
t the dear by the air tached fo	/sic	1 Yes 2 X No 4	□ Pregnant at time of □ Unknown	fdeath 5∟	Other (specify)					Month	Day Year
hat the	Physic	Part II. Other significant conditions contribut	ing to death but not re	esulting in the u	nderlying cause	given in Pa	rt I.	23e Did t	obacco u	se contribute t	to the cause of death?
res th signe	d by	Ţ.			, ,			1			Probably 4 🗷 Unknow
v requires the second speed signs should be	Completed										utopsy findings available
has law	dw							24a. Was auto			completion of cause of
s ician: The la certificate ha irector, page 3		25. Was case referred to medical				D. (D.		1 Yes			es 2 No
lor Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	To Be	examiner? 1 \(\sum \) Yes 2 \(\bar{X} \) No	ıl: 1 🔀 Inpatient 2 🗆	7 50/0-1	10	lthar:	eath (Check o				
g Physer this eral di			a. Date of injury	28b. Time of	28c. In	jury at		e 5 ∟ Res⊪ d. Describe l		Other (Spe	есіту)
ath. rr, After re funer	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury		ork? ∐Yes 2.[□ No				
or Attendafter deat Oirector; in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At h	nome, farm, stre	et, factory, offic	е	28				ural Route Number,
talon rs aft al Din led in			building, etc. (Specia	<i>(y)</i>				City or Tov	vn, State)		
To the Hospital of within 24 hours af To the Funeral Discompleted filled in	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: Or									tated. cause(s) and manner stat
the Ithe Ithe Ithe Ithe Ithe Ithe Ithe I	Me	only one) 3 Certifying Nurse Prac			leath occurred at	the time, da	ate and place,		e cause(s) and manner a	s stated.
7 wit		29b. Signature and title of certifier				nse number				e signed (Mon	
		1 a grafac	My	_		D3233	2		June	28, 2	
n 2		30. Name and address of person who complet Suresh K. Gupta, MD	ed cause of death (Ite		rint) Georgia	Δνα	MM C	to 220) 0-		20902 pring, Md.
Stat		31. Date filed (Month, Day, Year)	32. Register's Sign		corgia	71 V C .	MM DUT	LE 22(اد ر	TAGE 2	bring, ma.
Stat Registra	-	JUN 3 0 2011 Lener	32. Registrar's Sign	air							
IMH 17 Rev 7/20	09									•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne trunde Lane Severna avK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 13, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🗶M 2 🗆 F 90 298-12-8634 Director Argenti na Usual Residence of Decedent or 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Severna Park Anne Arundel MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 707 Laurel Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Bace - American Indian. Armed Forces?

1 X Yes 2 No 1942-Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give Maryland 21215-0036 White 1946 1 ☐ Yes 2 XNo Specify: 3 ▼Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) Cryptologist should be filed with and Mental Hygien 7 is marked other th NSA 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ Louise Kessler Ernest Bauman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Laurel Lane Severna Park, MD 21146 Nancy Bauman Cristiano/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of June 21, 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from Metro Crematory, INC. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 Severna Park Funeral He Severna Park, MD 21146 Barranco & Sons, P.A. Home 495 Ritchie Hwy, Part 1. Enter the disease, or complic shock, or beart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between nset and Death Immediate Pause (Final Physician/ TROKE disease of condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iii)jury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Medical Box 68760 attending pł I for use as tl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown 9 Unknown signed by ti Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been sifuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury death. thin 24 hours after death.

the Funeral Director: A smpleted filled in by the fu 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) eand title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06-20-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end # 5 Per FH g91/ 7/14/2011 Jh State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 22, 2011 3:05 A M June Bosmajian, Jr. George /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Arnold FutureCare-Chesapeake Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 ☐ F California 90 21,1921 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Anne Arundel Annapolis MD Director 28a-f 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ō within 72 hours after death with USA 21409 1511 Feral Dae Lane 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? items 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) marked other than Elementary/Secondary (0-12) 2 should be filed within and Mental Hygiene. Federal Government Research Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel White George Bosmajian, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health ar item 27 is 1511 Feral Dae Lane Annapolis, MD 21409 Shirley N. Bosmajian / Wife permit. Pages 1 a
Department of He
Important: If item
any injury or othe Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 23, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, INC. 2011 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee Severna Park, MD 21146 495 Ritchie Hwy, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 days Physician oneumonia resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit and Due to (or as a consequence of): Box 68760. physician the death certificate be Physician/Medical attending IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2☐No detached P.O. the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has 2 DNO 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred t examiner? edica 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **T**MO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred f Death 28c. Injury at Work? After 1 Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I or Attend after death Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a 24 hours a 29a, Certifier reftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) rans Huy Millers v. le M81108

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

END#8cerFH.6/28/11:BWW.Mcco

Certificate of Death

Reg. NZ 0 1 2

			1 - State Of Mary Registra MEND#80erFH, 6/28/11; BW. McCo	0	tificate of Death		Reg.	2011	22248	
	Physicia		1. Decedent's Name (First, Middle, Last) A pril Brozell				Date of Death Month June 6,		3. Time of Death 16:12 рм	
	Medic Examin		4a. Facility Name (if not institution, give street and number) Gladys Noon Spelman Nursing	Center	4b. City, Town, or Locatio			4c. County of Death	orges	
	Funeral Director			775. last birthday) 37 Yrs.		der 24 Hrs. 8. I	Date of Birth Month, Day, Yea ug • 13	1973 9. Birthr 1976 Coun	place (State or Foreign	
		Director	Md Dringe Coorges	. City, Town or Loc					0d. Inside City Limits 1 ✓ Yes 2 No	
	with the M 23a or 2 1st be no	Funeral Di	10e. Street and Number 2900 Mercy Lane		10f. Zip Code 20785			Citizen of What Cour	try?	
036	if filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Nas Decedent of Hispanic C f Yes, specify Cuban, Mexic I ☐ Yes 2 🌠 No Speci		Yes or No- n, etc.)	14. Race - Americ Black, White, of Specify: B16	etc.	
21215-0036	vithin 72 hour pene. sr than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) Spec. Ed. College (1-4 or 5+)	life. Do	dent's Usual Occupation kind of work done during me O NOT use retired) Day Program	nost of working	16b	Day Progr		
and		To Be	17. Father's Name (First, Middle, Last) James Brozell			other's Name (Fir Colleen		en Surname)		
Maryland	shc h an 7 is trau		19a. Informant's Name/Relationship (Type, Print) Robin Exton Service Coord		ng Address (Street and Num. 1125 15th				Dode)	
Baltimore,	. Page 1 and 2 Iment of Healt tant: If item 2 jury or other 1		20a. Method of Disposition 20	b. Place of Dispo	natory or other place)	Date 06/20/2		. Location - City or To	·	
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Livens	22	Name and Address of Factors 3447 14th St	cility Funeral treet, N	Home Wa	Inc. shington,	DC 20010	
	Tıysician		23a. Part 1. Enter the disease, or complications that caused the caused the cause (Final disease or condition resulting in death)	death. Do not ente	er the mode of dying, such a	as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death	
) Medical Examiner	Į.	Sequentially list conditions.	SHO	ns "					
	outed nd runsii	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	e (Disease or iinjury initiated events c						
/60	icate be executed physician and streets the burial-transi	Aedical E	resulting in death) Last Due to (or as a constant d	sequence of):						
Rox eg	death certif ne attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year	
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Kecc	The law ate has page 2	Completed					24a. Was an autopsy performed 1 Yes 2 X	prior to co death?	psy findings available mpletion of cause of 2½ No	
Vital	ysician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	ER/Outpatier	Other:	Death (Check only		6 Other (Specify	·)	
on of	nding Phy ath. "After thi e funeral		27. Manner of Death 1 ▼ Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year	28b. Time of		28d.	Describe how in			
JINISIC	al or Atte s after des I Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		eet, factory, office			and Number or Rura ate)	Route Number,	
_	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examinonly one) 1 X Certifying Physician: To the basis of examinonly one) 1 Certifying Nurse Practioner: To the basis	ation and/or invest	tigation, in my opinion, death	n occurred at the	time, date and pla	ace, and due to the ca	use(s) and manner stated.	
	To th within To th comp	~	29b. Signature and title of certifier		29c. License numbe	77	29d.	Date signed (Month,	Day, Year)	
			30. Name and address of person who completed cause of common Ophnell Cumberbatch, M.D.	nem 23a) (Type, F 8416 (Print) Central Ave.,	, Lando	over, Md			
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature par	W	_				

Physician
/Medica
Examine

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 233

Baltimore, Maryland 21215-0036

Physi /Med

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending physician and Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of M	arylan		rtificate of	lealth and M Death	, 0	2011	22249
ysicia	n	James R. Bu							Day Year	3. Time of Death
Medica camine		4a. Facility Name (If not institute				4b. City, Town, o	Location of Death	6 22	2011 4c. County of Deat	1714p M
neral		28178 Revel. 5. Social Security Number 166-28-8074	s Neck Road	l je (In yrs. i	last birthday) Yrs.	Westove If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye. 7 – 24 – 193	ar) Co.	hplace (State or Foreign untry)
ħ		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City	y, Town or Lo	cation				10d. Inside City Limits
rottfie	Director	MD Some	erset	Wes	stover	10f. Zip Code		10g.	Citizen of What Co	1 □Yes 2 No untry?
ed ter	<u>a</u>	28178 Revel:	s Neck Road	l		21871		US	SA	
- FR	by Funeral	11, Marital Status 1 □ Never Married 2 ☒ Ma 3 □ Widowed 4 □ Divorce	If Yes Give	No		Was Decedent of H fYes, specify Cuba I∐Yes 2፟∑No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Spe Whit	e, etc.
ne Medical	Completed	(Specify only high Elementary/Secondary (0-12)	ent's Education hest grade completed)) College (1-4or 5	ō+)	(Give life. l		ation during most of worki t)	ing	. Kind of Business/	·
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matic e	10	James R. Bu			19h Mailir	ng Address (Street		Shoemake		7in Code)
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ıry or oth		20a. Method of Disposition	n 3 Removal from State			sition (Name of natory or other place) n Cem		20c – 2011 Hu	Location - City or urlock,	
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	Examiner	23a. Part1. Enter 1.— fissishock, or heart fat life. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as Due to (or a)	a consequence a consequence	Con uence of): in tiga uence of): Fit	cer	1			Interval Between Onset and Death
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uld be der	2	Part II. Other significant condi	tions contributing to death b	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.		co use contribute to	o the cause of death?
r, page 2 sho	Completed							24a. Was an autopsy performed 1 □ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of 2 □No
ig	ation: Io Be	25. Was case referred to medical examiner? 1								
lled in by th	Certification:	2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Ste							tate)	
pletely fi	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ying Physician: To the best al Examiner: On the basis of and manner st	of examina	wledge, death tion and/or in	h occurred at the ti vestigation, in my o	me, date and place, ppinion, death occur	and due to the caus red at the time, date	se(s) and manner a and place, and due	s stated. e to the cause(s)
com	Ž	29b. Signature and title of certif	ier	111	10	29c. Licens	e number	29d.	Date signed (Mont	h, Day, Year)
		30. Name and address of person	s mo loo A	death (Item	1 23a) (Type,	Print) Salis	stury	Md.	1231	1/
Stat egistra	e r	31. Date filed (Month, Day, Yea JUN 2 3	2011 32. Registr	ar's Signa	ture	w)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22250 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE 21, Physician/ 2011 ROBERT ANDREW BERKHEIMER 1737 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** APRIL 26 1 🕅 M 2 🗆 F Days Hours MARYLAND Director 220-30-4517 76 Yrs. Usual Residence of Decedent or 28a-f show e notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 🗆 Yes 2 😾 No DELAWARE SUSSEX SELBYVILLE 10g. Citizen of What Country? 10e. Street and Number ò ral", or items 23a o Examiner must be Funeral 19975 USA 37047 PINTAIL DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 If Yes, Give Black, White, etc. 1 ☐ Never Married 2 🔀 Married Completed by 2 No Specify: WHITE 1 ☐ Yes 2 X No Specify. "natural", 3 🗌 Widowed 4 🗆 Divorced Year or Dates. 55-59 is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) MOTOR VEHICLE STATE OF MARYLAND INVESTIGATOR -Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPHINE E. STAUDENMAIER HERBERT D. BERKHEIMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37047 PINTAIL DRIVE, SELBYVILLE, DE 19975 KATHERINE M. BERKHEIMER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 Department of I Important: If it 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 6/25/11 BALTIMORE, MD 21. Signa re o F n ral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Du- o (or as a consequence of) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 9 Unknown 9 Unknown P.O. Part II other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 1 Yes 2 No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 24 hours after deatl Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 2225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ UXTIS Gina Medical JUNE 30.2011 10:30A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENESIS WALDORF CENTER WALDORF CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign 1 - M 2 - F Months Days Min. Hours 4-6-1923 WASH., D.C. 577-20-7091 **Director** 88 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 🗆 Yes 2🏝 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 11060 WEYMOUTH COURT 20603 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BOOKKEEPER BANKS 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ HORACE L. ANDERSON MAUDE GINE TOLLEFSEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra SUSAN AUGHINBAUGH-DAUGHTER 5355 JANORE CT. MARBURY, MD. 20658 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State EPIPHANY CH.CEMETERY 7-7-11 4 Donation 5 Other (Specify) FORESTVILLE, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Juneral Service Licensee M00479 u 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ bolenou Medical Due to (or as a consequence of): Examiner Si Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of and I-transit death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f 2 No 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ brillation, Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an the Hospital or Attending Physician: The law autopsy performe 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 24 hours after death. Funeral Director: A Accident
Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) water Colony Drive iA, Annapolis, MD

State Registrar

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catania 8:53P M Juliette Louise June 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Days Min. 1 🗆 M 2 🔀 F 87 017-16-1576 Director Massachusetts Tune Usual Residence of Decedent Fshow 10d. Inside City Limits or 28a-f shov notified at 10a, State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗵 No Silver Spring Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or than "natural", or items 23a of the Medical Examiner must be Funeral 20906 United States 15300 Beaverbrook Court, Apt. 26 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mee once. Elementary/Seconday (0-12) College (1-4 or 5+) Denta1 Hygienist 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elizabeth Gaudereau Frank Carrier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16076A A.E. Mullinix Road, Woodbine, Md. 21797 Andre Coutu/Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State Silver Spring, Md. 6/27/11 Gate of Heaven Cem. 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility}
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, . Signature of Funeral Service Licensee 20882 >au 23a. Part 1. En to he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant been signed by the should be detached P.O. þ Records, has page 2

Box 68760

Completed Be 25 ည 27. Manner of Death Medical Certificate:

1 Yes 2 No	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Month Day	Todi
	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause	
		24a. Was an autopsy performed?	24b. Were autopsy finding prior to completion death? 1 Yes 2 No	of cause of
. Was case referred to medical	26. Place of Death (Check	only one)		
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Specify)	

28c. Injury at

	1 Natural 2 Accident	5 Pending Investigation	(Month, Day, Year)	injury M	work? 1 ☐ Yes 2 ☐ No			
	3 ☐ Suicide 4 ☐ Homicide	6 U Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		ry, office		n (Street and Number or Rural Route Numbe Town, State)	ľ,
	29a, Certifier 1 (Check 2 only one)	Medical Examine	r. On the basis of examination	n and/or investigation, i	n my opinion, death occurre	d at the time, dat	cause(s) and manner as stated. te and place, and due to the cause(s) and man o the cause(s) and manner as stated.	ner state
_	29b. Signature and	/	/ /		D0070.	195	29d. Date Agned (Mohth, Day, Year) 6/2/2011	

10

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

funeral director,

completed filled in by the

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raphael G. Loutoby, M.D.

18101 Prince Philip Drive, Olney, Md. 20832

28d. Describe how injury occurred

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

28a. Date of injury (Month, Day, Year)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Month FRANK CORREA /Medical JUNE 2011 9:30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COUNTRY LIVING ASSISTED LIVING POOLESVILLE MONTGOMERY 5. Social Security Number 8. Date of Birth (Month, Day, Year) 05/23/1921 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days PUERTO RICO 125-26-0071 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho treumetic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No MD MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9305 BELMART ROAD 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 3 ☐ Married Baltimore, Maryland 21215-0036 Specify: PUERTO 1 ⊠Yes 2 □ No þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE RICAN Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY 12 should be filed with and Mental Hygier 7 is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NICOLAS CORREA BELEN TORRENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: if item 27 is permit. Pages 1 and 2 Department of Health Important: if Item 27 any Injury or other tru DR. FRANCISCO CORREA/SON 9305 BELMART RD., POTOMAC, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. CHARLES
CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/28/2011 PINELAWN, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE resulting in death) /Medical Due to (or as a consequence of). Examiner HYPERTENSION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or de a consequence of). The law requires that the death certificate be executed HYPOTHYROIDISM physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 5 ☐ Other (specify) by the tached ☐Yes 2☐No 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: filled in by 24 hours within 2 To the

> 5 State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

VINU GANTI,

and manner stated.

9nti

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D41162

29d. Date signed (Month, Day, Year)

June 23, 2011

		Ľ	1 - For State Registrar	te of Marylaı	nd / Depa <i>Cei</i>	artment of H	lealth and Death	Mental Hygi	2011	22254
		13	Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medio		Calvin Wheeler Cl	ark					22 201	B. 4
	Examin		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or		th	4c. County of De	
			5300 Riggs Road 5. Social Security Number 6. Sex	7 Age /la yrs	. last birthday)	Gaithe If Under 1 Year	ersburg	8. Date of Birth		gomery
В	Funeral Director		218-66-4012		Yrs.	Months Days	Hours Mir	. (Month, Day,		irthplace (State or Foreign Country) aryland
			Usual Residence of Decedent					Dec. II	1999 11	
	show	_	Md. Montgomery	10c. C	ity, Town or Lo	cation hersburg				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	10e. Street and Number		Gail	10f. Zip Code		10	g. Citizen of What	
	with with		5300 Riggs Road				20882	, ,	_	States
	death ms 2;	Funeral	11. Marital Status 12. Wa	s Decedent Ever in I	U.S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - Ar	nerican Indian,
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther then "naturel", or Items 23s or 28s-f show yth, Ite Modical Exact must be Lightled at	δ	1 ☐ Never Married 2 ☑ Married 1 ☐	ned Forces?]Yes 2⊠No es.Give ar or Dates:			Specify:	rto Hican, etc.)	Specify:	White
20	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Dece	lent's Usual Occup	ation during most of w		6b. Kind of Busines	ss/Industry
2	Jwithin 72 ho piene. r then "natur tre Modical	mple	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	life.	DO NOT use retired	d)			10.11
2	e filed within al Hygiene. I other then '		1.1 17. Father's Name (First, Middle, Last)	0	Se	curity Gu		me (First, Middle, M		Landfill
and	nd 2 should be filed lith and Mental Hyg 27 is merked other r treumatic event,	o Be	Raymond Clark, Jr.				Cathe			
ary	shou ind M mari umati	1	19a. Informant's Name/Relationship (Type, Pri	nt)	19b. Mailir	ng Address (Street	an <i>d Number</i> or F	tural Route Number,	City or Town, State	, Zip Code)
	of Health of Hea		Mary L. Clark W		530	- 00-	Road, G	aithersbu	-	20882
Baltimore,	of He of He or oth	1 5	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova	I from State	cemetery, crer	sition (Name of natory or other place	ρθ) (6.1		Oc. Location - City	
ţ	ment tent: jury o		' 4 ☐ Donation 5 ☐ Other (Specify)	Me	•	itan Cre		23/11	Атехап	dria, Va.
Bal	permit. Pages. Department of H importent: If ite eny injury or ot once.		21. Signature of Funeral Service Licensee	May	22		H. Barbe	r Funeral , Laytons		. 20882
		ji l	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the dea e on each line.	ath. Do not ent					Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)	Myocard	dial In	farction				1 day
	/Medical Examiner		resulting in death)	ue to (or as a conse	equence of):					
		ē		ue to (or as a conse	quence of):					
	outed id ansit	Examlne	cause. Enter Underlying Cause (Disease or Injury that initiated events							
oʻ	ate be executed hysician and the burial-transit	Exa		lue to (or as a conse	equence of):					
8760,	ate hy the	dlcal	d							
9	death certific e attending pl d for use as 1	/Me	IF FEMALE: 23c. If y	es, outcome of pregr	nancv				23d. Date of	delivery
Вох	atten d for u	Physician/M	in the past 12 months?	Live birth 2 Fet Pregnant at time of	tal death 3[Ectopic pregnancy Other (specify)	/		Month	Day Year
0.	tt the d by the tached	hys	9 Unknown 9	Unknown						
S, P	res tha igned be det	by P	Part II. Other significant conditions contribution	ig to death but not re	sulting in the u	nderlying cause giv	en in Part I.			to the cause of death?
ord	w requir been si should l							1 🗆 Yes	s 2 □ No 3 □	Probably 4 / Unknown
Vital Record	he tare has age 2	Completed		4,000				24a. Was an autopsy perform	ed? prior death	autopsy findings available to completion of cause of ? es 2 \[\sum \text{No} \]
/ita	certificat	Be (25. Was case referred to medical examiner?					eath (Check only one		
of \	Physicien: this certific ral director,	2	1 Yes 2 No Hospita	1 Inpatient 2	ER/Outpatier			Home 5 Resider		pecify)
nc	Jing F	lon	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	28b. Time o Injury	Wor		28d. Describe how	w injury occurred	
Division	Attending ar death. ector: Atter by the fune	ertification;	3 Suicide 6 Could not be	Place of Injury - At I	home, farm, str			28f. Location (Str	eet and Number or	Rural Route Number,
Dİ	i i i i i i i i i i i i i i i i i i i	Certi	4 Homicide	building, etc. (Spec	city)			City or Town,	State)	
	Hos Fur tely	edical (29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or an							
	To the within 2 To the compler	Me	29b. Signature and title of certifier	Physi	cica	29c. Licens		29	d. Date signed (Mo	
)			· United	1 '/'		D	0055694		June +	22, 2011
	5		30. Name and address of person who complete Alok Mathur, M.D.				Road, 0	lney, Md.	20832	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		/				***
	Regist	ar	MIN 2.4 2011	Densera	_ B L	barker				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22255 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 25 2011 Physician/ Month Dennis Patrick Carr 02:30A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death castal Hospice at the lisbun Wicomica **Funeral** 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth 1 DXM 2 D F Months Hours Min 5 / 24 / 1930 Director 214-26-2391 81 MD Usual Residence of Decedent or 28a-f shov ntal Hygiene. ed other than "natural", or items 23a or 28a-f shovevent, the Me Ilical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Worcester Ocean Pines 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1135 21811 USA Ocean Parkway B 11 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo Specify: 3 Widowed 4 X Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Police Officer Law Enforcement is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John J. Carr Mary E. Kennedy any injury or other traumatic permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Cox / friend MD 21811 11421 Manklin Creek Rd., A8, Berlin, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 6/28/11 Timonium, MD 21. Signature of uneral Service Lice 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or imputhat initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2. No Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **N**o ဂ္ 1 Yes Other: 6 Dother (Specify) Hostice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No s after death | Director; A d in by the fo Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide 24 hours a Funeral E Medical 20a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

To the F

complet 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 6/73/11 D63199

Registrar

DHMH 17 Rev 7/2009

State

5+1

Registrar's Signatur

SHOKE

SALISBURY, MD, 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

31. Date filed (Month, Day, Year)

JUN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22256 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 17, Day 2011 332 AM M Edward William Condon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Year 1931 July 5, Maryland 214-28-7786 79 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 1 Yes 2 ☐ No MD Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20876 United States 19221 Deep Run Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

Yes 2 \[\] No Black, White, etc. 1 Never Married 2 X Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1952-1953 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working United States life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Postal Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marian Bullard Joseph Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19221 Deep Run Court Germantown MD 20876 19a. Informant's Name/Relationship (Type, Print) Marian Prowant - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville Vet Cem 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/24/2011 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility M01163 Danzansky-Goldberg Memorial Chapels Inc MD 20582 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final Malianant minuste disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to lor as a conse juence of Due to (or as a consequence of): IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Obstructive Pulmonary Disease 24a Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No

Examine physician w.s. the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760 signed by the at Id be detached fo within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s

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19061

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

28a-f shov

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/

Medical

Examiner

21215-0036

Baltimore, Maryland

Physician/Medical þ Completed Be ပ Certificate: Medical

Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Sig ture and title of bertifie 29c. License number 29d. Date signed (Month, Day, Year,

D005802

June

201

me and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Cur Dr Rockville, MD MD

Registrar's Sign

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 7 2011

		1	For State	State of Ma	aryland /		ertment of H		Mental Hy	giene Reg. N20		22257
Physic	oian	,	1. Decedent's Name (First, Middle, Last	"	1			- Catif	2. Date of De	ath	Year .	3. Time of Death
Me	dica		4a. Facility Name (if not institution, give	Lee (ul	00 a	4b. City, Town, or	Location of Dag		Day 15, 3	2011	643 A.M.
Exan	nine		12766B Catoctin Ho		l		**	urmont			reder	ick
Funer Directe			5. Social Security Number 6. Se 212–72–6933	X M 2 □ F 7. Age	(In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			g. Birthp Coun Penn	olace (State or Foreign try) sylvania
and show at			Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation				1	0d. Inside City Limits
Maryla 28a-f		lrect	Maryland Freder	ick				Thurm	ont			1 ☐ Yes 2 🛣 No
with the 23a or		Funeral Director	10e. Street and Number 12766B Catoctin He	ollow Road	i		10f. Zip Code	21788		10g. Citizen of V	Vhat Cour JSA	try?
Iore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Completed by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 No	, Mexican, Puer			k, White,	
21215-0036 within 72 hours after giene. ier than "natural", o		npier	15. Decedent's Ed (Specify only highest gra	de completed)		(Give k	ent's Usual Occupa ind of work done du NOT use retired)	tion uring most of wo	orking	16b. Kind of Bu	isiness Ind	dustry
212 within vgiene.		5	Elementary/Seconday (0-12)	College (1-4 or 5	+)		uck Drive	er		Tran	nspor	tation
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event		10 Be	17. Father's Name (First, Middle, Last) Garland Cubb	age					me (First, Middle, zabeth Mi	Maiden Surname .tchell)	
Mary 2 should Ith and Ma 27 is mar			19a. Informant's Name/Relationship (Ty) Deanna Cubbage, W.				g Address (Street ar					
Baltimore, M Dermit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr			20a. Method of Disposition 1 Burial 2 Cremation 3 4 One Donation 5 Other (Specify	Removal from State	20b. Place		sition (Name of ard) Sr other place	,)	Date 20/2011	20c. Location - Manche	City or To	wn, State
Baltimo permit. Page Department Important: I	ouce.	1	21. Signiture of Funeral Service License	e / / /rex	`A. 5	22.	Name and Address		Myers-Du St, Tane	rboraw Heytown, N	Tuner 1D 21	al Home 787
Pnysician Medic Examine	al er	1	23a. Part 1. Enter the disease, or comp sheet, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	lications that caused e cause on each line a. Due to (or as a		/	Asystol Hup	, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death Seconde
certificate be executed certificate be executed and physician and use as the burial-transit	Evaminor		if any, leading to immediate Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a			4	Ууроры	ea, N	arcosis		hours
the ate	logical	enica		d	Se	dah	in for p	ain ce	n trol			hours
Box death ne atte	Dhyeicisia/Mo	ysicially ly	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 🗌 Fetal de		Ectopic pregnancy Other (specify)			23d. Dat Mor	te of delive	Pry Day Year
Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	3	3	Part II. Other significant conditions co	nt sq	uamo	us 0	ell can	en in Part I.	1	obacco use contr Yes 2 🗌 No		e cause of death?
Division of Vital Records, lal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should b.	Completed			head &	- nec	km		he	1 Yes	psy primed2	Vere autor prior to con leath?	osy findings available impletion of cause of
n of Vital ding Physician: h. After this certific funeral director,	To Bo	5	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	nt 2 🗆 ER/9	Outpatient	Other	ce of Death (Che		dence 6 🗆 Othe	er (Specify	
n of ding Ph h. After th funeral			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day,		. Time of injury	28c. Injury work? M 1 🗆 Y	at ′es 2 □ No	28d. Describe l	now injury occurre	ed	
IVISIO I or Atten after deal Directors	Cortificato.		2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.		farm, stre		00 2 - 10	28f. Location (S City or Tov	Street and Number vn, State)	er or Rural	Route Number,
DIVISIO To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Modical	Lealical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examination) 3 Certifying Nurse	er: On the basis of ex	amination and	d/or investi	gation, in my opinior	, death occurred	at the time, date a	and place, and due	to the cau	use(s) and manner stated.
To the	2		29b. Signature and title of certifier	0/			29c License	number		29d Date signed	(Month I	Day Year)
WHZ		3	30. Name and address of person who	ompleted cause of de	1 0) (Type, Pr	int)	7/	7. 1	Fula	13/	2011 MD 21702
Si Si	tate		31. Date filed (Month, Day, Year) JUN 1 6 20	32. Pegistrai		111	omas J	ounsu	1 Drive	reae	TICK)
Regis	uar		2011 1 11 20	11 I maren	e B.	400	akes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Rav Ceriotti June 20, 2:20 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 🗆 F Min. (Month, Day, Year) an 3, 1942 69 Michigan Jan Director 376-40-9844 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director Taneytown 1 X Yes 2 ☐ No Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 132 Saddletop Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white and Mental Hygiene. is marked other than "natural", 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Chemical Company Chemical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Julia Yurgolydis Raymond Ceriotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Saddletop Drive, Taneytown, MD 21787 Mary Ceriotti, wife 20a. Method of Disposition 20b. Place of Disposition (Name of Ademeter anie in the or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crematory 6/22/2011 4 Donation 5 Other (Specify) Manchester, MD 21: Signature of Funeral Service Licensee 22. Name and Address of Facility
136 E Baltimore St, Taneytown, MD 21787 22. Name and Address of Facility 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MUSED CONNECTIVE TISSUE DISERS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of Exami and -transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Month Dav Year Yes 2 No ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ KAYNAUDS PHENOMENON 1 Yes 2 No 3 Probably 4 Unknown Completed SYNDROME 24b. Were autopsy findings available prior to completion of cause of has autopsy page perform death? After this certificate ARDITIS 2 🗆 🗖 1 Yes 1 🗌 Yes 25. Was case referred to medi Be 26. Place of Death (Check only one) Hospital: Other: 2 N 4 Nursing Home 5 Residence 6 Dether (Specify) NOSPICE မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No ☐ Natural 5 Pending thin 24 hours after death. the Funeral Director: Al mpleted filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

29b. Signature and title of certifier

address of person who completed cause of death (Item 23a) (Type, Prin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John William Crellin, Sr. 23^{Bay} 20 P June 04:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 07/06/1921 Louisiana Director 439-18-1348 89 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2544 North Haven Cove 21401 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces: If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Black, White, etc. Completed by 1 Never Married 2 Married al Hygiene. 1 Yes 2 No Specify: 3 ♥ Widowed 4 Divorced Year or Dates. WWII White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Chemist is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Nelson Crellin Olivia Bentel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or any John W. Crellin, Jr./Son 8119 Bird Lane, Greenbelt, Maryland 20768 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place)
Gate of Heaven Cem. 1 X Burial 2 Cremation 3 Removal from State 06/27/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a I for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No has page certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation 1 Yes 2 No Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

wis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

al Parkway Ste210

21401

11-04696 Olivia Constant Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

nivia Constant		1- For State Registrar	te of Maryland /	•	ent of Headate of Dea		, ,	201 Reg. No.	1 22261
Physic Medical Exam		Decedent's Name (First, Middle, OT TVTA DACUET C					2. Date of Do	Day Year	3. Time of Death 1630 hrs
company		OLIVIA RACHEL C			4b. City	, Town, or Location of	June 23	4c. County of De	
_		Anne Arundel Medical C		/le le et le le		apolis	out lo p-t	Anne Arund	
Funera Director		217-47-9434	. Sex 7. Age	(In yrs. last bir	Yrs.	ider 1 Year If Under ths Days Hours	Min.	8/1996	eign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County	- I	10c. City, Town	or Location	_		<u> </u>	10d. Inside City Limits
Maryland 28a-f show d at once,	Ö	MARYLAND ANNE A	RUNDEL	ANNAP	OLIS				1 Yes 2 No
e Mary or 28a-	Director	10e. Street and Number				ip Code		10g. Citizen of What C	ountry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	ra D	2021 MONTICELL 11. Marital Status	O DRIVE 12. Was Decedent E	ever in U.S.		21401 Dent of Hispanic Origin	n? (Specify Yes or N	USA No- 14. Race - Am	erican Indian, Black,
death or item	Funeral	1 X Never Married 2 Marr	1 Yes 2	X No	If Yes, spec	cify Cuban, Mexican, I	Puerto Rican, etc.)	White, etc	
		3 Widowed 4 Divorce 15. Decedent's Education (Specify	Ged If Yes, Give Yeer or Dates:	oloted) 160	-	No specify:	nd of work done	Specify: W	HITE
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. Tis marked other than "natural", or items 23a or 28a-f shu stift event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-			orking life. DO NOT u		top. Kind of Busines	s/industry
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2121 ould be fi d Mental s marked	To B	STEPHEN J. CONST		19	b. Mailing Addres	SS (Street and Numb	THY JAWORS or or Rural Route No	$rac{ extsf{SKI}}{ extsf{umber}}$ umber, City or Town, Sta	ate, Zip Code)
MD and 2 shot alth and 2 sign m 27 is		STEPHEN J. CONST	TANTS/FATHER			TICELLO DI		LIS, MD 214	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other trannatic event, the Medical Examiner.		1 X Burial 2 Cremation	3 Removal from State	oromo	of Disposition (Natory or other place こんでは、MEM	2)	Date	20c. Location - City	or Town, State
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ed ssit	Examiner	(Discase or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
Division of Vital Records, P.O. Box 68760, Bospital or Attending Physician: The law requires that the death certificate be executed Pubmirs after death. Furneral Direct After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED	d X AMENDEDItem Item 28a,pe	# 1 as	noted pe	r me,g917	7-26-11	sm	
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Division tal or Attendi rs after death.	ficat	2 ✓ Accident Investigation 2 ✓ Accident Investigation 3 Suicide 6 Could not be a suicide 6 Co	28e Place of Injur	y - At home, fa		y, office building, etc.	28f. Location		Rural Route Number, City
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		Maria	Vn	D		O.C.M.E.		June 24, 2011	
7.10		30. Name and address of person wh		. ,	000344 5 1	Aimana Ctarat D	Min	1000	
·HO	tate	Russell Alexander MD. 31. Date filed (Month, Day Year)	Assistant Medical		900 W. Bal	umore Street, Ba	animore, MD 21	1223	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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vith the Ma 23a or 28 st be noti	Funeral Director	10e. Street and Num 342 Pre		eld Lane			10f. Zi	p Code 211	46		10g. Citizen	of What Cou JSA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fune	11. Marital Status 1 Never Marri 3 Widowed	ied 2 🔀 Marrie	12. Was Decedent Armed Forces?	No 19	39 –	If Yes, spe	cify Cuba	ispanic Origin? (Spanic Origin?) In, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		lace - Amer lack, White ify: Wh		
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Page 1 ar nent of He ant: If iten ıry or oth		20a. Method of Disp 1 Burial 2 4 Donation		3 Removal from State pecify)	C	emetery, cr	oosition (Na ematory or remato	other plac	e) I.Tune		20c. Location	-		
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Physician/ / Medical Examiner			rt failure. List on Final	a. Due to (or as								ran	Approximate Interval Between Onset and Death	_
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To the within To the compl	M	only one) 3 29b. Signature and		Nurse Practioner: To the	A A	V.	29	c. License	number		29g Pate sig	ned (Month	Day, Year)	_
Hant	1	30 Name and addre	ess of person w	The completed cause of c	leath (Item	23a) (Type	Print)	YFN.	21438 ISE Awy	ANNY	Pouls	Mo	21401	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death 24^{Day} Physician/ 06^{Month} 201°T Wayne Everett Calhoun 9.00 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Lanham 6918 Lamont Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 XM 2 □ F Months Days o#7112711952 Washington, DC Director 58 578-68-8374 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Prince George's Lanham MD 1 x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20706 6918 Lamont Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Yes Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Heatth and Mental Hygiene. Important: If item 27 is marked of ther than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Conductor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Olivia Hines Melvin Calhoun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2615\,$ Newton Street NE Washington, DC $20018\,$ 19a. Informant's Name/Relationship (Type, Print) Michael Calhoun/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 07/02/2011 Landover, MD 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resciratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death atheroscientic Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on. Exami that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, nours after death.

neral Director: After this
d filled in by the funeral di this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 20

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
JUN 3 0 2011

Christina Gillespie 4151 Bladensburg Road Brentwood, MD 20722

30. Name and address of person who completed cause of death (cem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 22263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 ANDREW CANN 7:31 PM 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD MEMORIAL HUSPITAL HAVRE DE GRACE HARFORD Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) 02/07/1929 Pennsylvania 1 X M 2 □ F Hours Director <u> 148-18-8541</u> "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a, State . Page 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hyglene. At last If flew 22 is marked other than "natural", or items 23a or 28a-f sho land to other traunatic event, the Medical Examiner must be notified at jury or other traunatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🖔 No <u>Havre de Grace</u> <u>Harkord</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Box 445 40 Robin Hood Road 21078 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1946-48 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto/Truck Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marguerite Hallman Ralph A. Cann. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Cann (Wife) 40 Robin Hood Road, Box 445, Havre de Grace, MD 2107 8 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Philadelphia Crematory 07/08/2011 Philadelphia, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. Maryland Washington St, Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ artery disease bronary disease or condition Medical resulting in death) Due to (or as a consequen of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by embolus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ 1 🗌 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certi 29b. Signature EMERCENCY PHYSICIAN

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of po

1 3 2011

TIMOTHY CH 31. Date filed (Month, Day, Year, 501 S. UNION AVE HAVREDEGRACE MO 2/078

who completed cause of death (Item 23a) (Type, Print)

mo

CHIZMAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22264 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1135 AM Zoila Medina Caamano 2011 . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical HICOMICO RODONAL 502/84/1 If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days 1271471935 098-36-9396 75 Dominican Republic Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Delmar Wicomico 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21875 USA 9301 Colonial Mill Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 🗷 Yes 2 □ No Specify: Dominican Caucasion ould be filed within (2.1.2.) and Mental Hygiene.
is marked other than "natural"
....vent, the Medical Ey Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o ျ Juana Maria Medina Pedro Plutarco Caamano Medina Department of Health and Important: If item 27 is m. any injury or other traumone. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9301 Colonial Mill Drive, Delmar, MD 21875 19a. Informant's Name/Relationship (Type, Print) Richard A. Mendoza/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 06/23/2011 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E Grove Street, Delmar, DE 19940 23a. Part 1. Enter the disease, or compile shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. Interval Between Immediate Cause (Final Onset and Death INTIA CEREBIAL Physician/ disease or condition 1 day Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autops\ performed 2 🗌 No ☐ Yes Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 5 Pending Natural 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3TA ST, SALISBURY MO 21801

State Registrar NATESAN

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital Records,

100 €.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1236 2011 Lee Cannon Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula VICOMICO RECHONAL Medical Conto Sex 1 A M 2 A F 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. 01113 1936 75 Maryland 217-30-9195 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21830 USA 27091 S. Tourmaline Dr. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ed other than "natural", or iter event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates. Army 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 Pof Health and Mental Hygiene. item 27 is marked other than "nother traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare LPN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helma Parsons Robert Lee Cannon Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27091 S. Tourmaline Dr., Hebron, Maryland 21830 Mary Lou Cannon wife item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott ☐ Burial 2 X Cremation 3 ☐ Removal from State 06 16 2011 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Accidental Fall Medical resulting in death) Due to (or as a consequence of) Examiner Subdural hematoma Sequentially list conditions, if a yellowing to immediate cause. Enter Underlying Examine Metastatic Cause (Disease or iinjury that initiated events resulting in death) Last carcinoma that the death certificate be executed Un thelial and attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a, Was an has performed? this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Unrector After this certifica completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred ☐ Natural ☐ Accident 5 Pending 5:00 a M 1 Yes 2 No 15/11 Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Spe Unit Salishu 100 E Carroll St. Transitural Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinal on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best death occumid at the time, date and place, and due to the cause(s) and m H50497 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6/16/11 29c. License number 06 /15/11 168222 1/9 em 23a) (Type, Print) 30. Name and address of person who completed cause of death HRISTOATEN SNYDER 100 E. Carpour ST

Registrar

State

JUN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician/ Sonald 30 CHAMIO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sa Himore march law 04 8. Date of Birth (Month, Day, July 19 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Sex 1 AM 2 F Age (In yrs. last birthday) Social Security Number **Funeral** Months Min. Days Hours 1946 Yrs DC Director 578-58-2765 64 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he mattered at 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 No Bowie Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 20716 15807 Paramont Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Warehouse Manager 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mattie Taylor Louis Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, Md. 20716 15807 Paramont Lane Elverda Mae Cunningham - Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 2011 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licenses once. 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TUPEA. Dontre Ph_sician/ Anour 45mm disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ysician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending physi for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ↓ Unknown Division of Vital Records, Completed neral Director: After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No death? 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 24 hours after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined ca Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 06 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

JUN 2 9 2011

32. Registra Signa

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	olato ol marylan	Cei	rtificate of	Death	Reg	2011	22201		
	Physici	an	1. Decedent's Name (First, Middle, Las	,	Die	ahal		2. Date of Death July 5,	2011 Year	3. Time of Death		
-	/Media	cal	Dolor 4a. Facility Name (If not institution, giv		DIS	chel	r Location of Death	July 5,	4c. County of Death	11:15 pm		
1	Examir	ner	Kline Hospice H			_	nt Airy		Frederic			
	Funeral Director		5. Social Security Number 6. S 530–18–1013	ex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Jan 15,	9. Birth Cou 1920 Pue	place (State or Foreign intry) erto Rico		
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
	ne Maryli 18a-f sho	ector	Maryland Frederi			derick				1⊠Yes 2 No		
	ath with the 23a or 2 ust by n	Funeral Director	155 Willowdale D	rive, # 24			21702		U.S.A.	ntry?		
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Midtol Evandra" is ust by notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☑ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Hi	etc.		
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Maryland 21215-0036	uld be fileo Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Ramon		ortegu	era	18. Mother's Nam Aurea	e (First, Middle, Ma	aiden Surname) Lopez	3		
	alth and N		19a. Informant's Name/Relationship (Frank Dischel, S			illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Hillcrest Drive, Frederick, Maryland 21703						
Baltimore,	Pa Fig. 1		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Removal from State	emeterv. crei	Disposition (Name of community of the place) Date 20c. Location - City or Town, State 20c. Community of Town, State 20c. Smithsburg, Maryland						
Balti	Smithst Smit					22 Kreeney Bastord P.A. Funeral Home						
q	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death	Do not ent		ng, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death		
and the	Examiner		Coguantially list conditions	h	derice or _f .							
:	ed sit	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	sence offy:							
<u>,</u>	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):							
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rds, P.	quires that the de n signed by the uld be detached	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	ncco use contribute to			
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Division	al or Attend s after death al Director: ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	al Route Number,		
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	/ .	Ž	29b. Signature and title of certifier	Such mi)		29c. Licens	8104	29	d. Date signed (Month	- 11		
	Co Sm		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) Freder	rick, M	D217	701			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1						
	Registr	strar JUL 13 2011 Beneva B. Sparks										

DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and

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or 28	₫	10e. Street and Number	CIICH	-		10f. Zip Code			10g. Citizen	of What Cou	untry?	
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death item		11. Marital Status	12. Was Decedent Armed Forces	?	13. \	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White		
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of xaminer: On the basis of	of my knowled	lge, death	occured at the time	e, date and place, a	and due to the ca	use(s) and m	anner as sta	ated.	nner stated
the H hin 24 the Fi	Me	only one) 3 Certifying	Nurse Practioner: To th			death occurred at the	ne time, date and pla		e cause(s) an	d manner as	stated.	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month & William Garnett Dorsey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Alice Manor Nursing Home Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2 □ F Hours Country) 1172971942 Director 212-38-1124 MD 68 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? pe Funeral er than "natural", or items 23a the Medical Examiner must b 21211 USA 2095 Rockrose Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes No If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3X Widowed 4 ☐ Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Pier One Maintenance Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Bertie Lucretia Dorsey Edward Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s James Dorsey/brother 2838 Ashland Avenue, Baltimore, MD permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Strawbridge Cemetery | June 25, 11 New Windsor, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pritts Funeral Home & Chapel -V 412 Washington Road, Westminster, MD Enter the disease, or complications that caused the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Sen Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi that initiated events resulting in death) Last by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 Tes or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. Ineral Director: After Natural 5 \square Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State JUN 2

DHMH 17 Rev 7/2009

Registrar

		_	For State	State of	f Marylan		irtmen <i>tificate</i>			d Menta	, ,		1.1	22270
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	uncate	: OI D	eaur	2. Da	Reg ate of Death	. No 20	1 1	3. Time of Death
	Physicia Medic		James Sh	rwood!	Davis					Mo	onth 6	Day 2.5	Year	7:38 PM
	Examin		4a. Facility Name (if not institution, g		ber)		, , , , , ,		Location of De	eath		4c. County		
eres ^{re}	Francis		Civista Medical 5. Social Security Number		7. Age (In yrs. Ia	ast birthdav)	LaP If Under	lata 1 Year	If Under 24 h		te of Birth		arles 9. Birthp	lace (State or Foreign
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	nd now at	١	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation							0d. Inside City Limits
	farylar 8a-f sl	ectc	Maryland St. M	lary's		Hollyw	ood							1 ☐ Yes 2 X ☐ No
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	th with ms 23 must	Funeral Director	25148 Gallant Fo		1-15	2 110 11	Var Danad	206	36 spanic Origin?	(Cnosify Vo	o or No		SA	
0	er dea or itel niner		11. Marital Status1 ☐ Never Married 2 X Marrie	Armed For	2 No Ari	nv l	Yes, speci	fy Cubar	n, Mexican, Pu	uerto Rican,	etc.)		ce - America ck, White, e	itc.
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212	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1- 2+	4 or 5+)				echnic	ian		are F	usion	
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Z	should be filed wit and Mental Hygie is marked other raumatic event, tt		James Sherwood I		•	10h Mailin	a Addross	(Street 2	nd Number or		Shoema		Stata Zin C	tode)
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Baltimore,	ge 1 and 2 nt of Healti : If item 2 or other 1		20a. Method of Disposition 1 Ⅺ Burial 2 ☐ Cremation		20b. F	Place of Dispo emetery, cren	sition (Nam	e of her place	e)	Date	20	c. Location	- City or To	wn, State
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Вох	e death the att hed for	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregr 9 ☐ Unkn	nant at time of o	death 5	Other (sp	ecify)				M	onth	Day Year
P.O.	requires that the de been signed by the should be detached	y Ph	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the u	nderlying o	ause giv	en in Part I.	2	3e. Did toba	cco use con	tribute to th	e cause of death?
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COL	aw rec las bee	Completed by	hyper dension	nk						2	4a. Was an autopsy		prior to co	osy findings available mpletion of cause of
Division of Vital Records,	The licate h	S	OF Was and referred to a section						15 11 "		performe	oa? No	death? 1 Yes	2 🗆 No
<u>lital</u>	rsiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	EB/Outpatier	nt 3 □ DC	LOUI.	ace of Death (C		one) □ Resideno	e 6 □ Oth	ner (Specify)
of	ng Phy ter this neral o		27. Manner of Death 1 K Natural 5 Pending	28a. Date		28b. Time of injury		Bc. Injury work	at		escribe how			
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ш	To the Hospital or Attending Physician: The law requires that the within F1 hours after death. To the F1 hours after death. To the F4 hours after death. To the F4 hours after death. To complete filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 **Certifying Check 2 ** Medical Ex	Physician: To the b	est of my know	ledge, death o	occured at	the time,	date and place	ce, and due	to the cause	(s) and man	ner as state	d. use(s) and manner stated.
	the H thin 24 the F	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best of m	y knowledge, o	death occur	red at the	time, date and	d place, and	due to the ca	use(s) and m	nanner as st	ated.
	5 × 5 0		Sobre Signature and title of Certifier	ou M	0		230		2597		6	-28 -	11	,, , ,
20			30. Name and address of person w	ho completed caus	e of death (Iten	n 23a) (Type, F	Print)							20650
K	65		31. Date filed (Month, Day, Year)	C. Brown	gistrar's Signa	26	840	Poi	NT LOC	skow	tro.	LEON	ANDTI	am wis
	Sta Registr		JUN 2 S	3 2011	gistrar's Signa	A. A	ark	_						

CLARENCE & DERRICOTTE JUNE 21, 2011 2242-

Division of Vital Records, P.O. Box 68760

December Security Description Descri		Please Type or Print in Black		-	gible.
Physician Medical Examiner Clarence Bruce Derricotte Shady Grove Adventist Hospital Ab. City, Town, or Location of Death Shady Grove Adventist Hospital Ab. City, Town, or Location of Death Shady Grove Adventist Hospital Ab. City, Town, or Location of Death Montgomery Shady Grove Adventist Hospital Ab. City, Town, or Location of Death Montgomery Shady Grove Adventist Hospital Ab. City, Town, or Location of Death Montgomery Ac. County of Death Montgomery Ab. City, Town, or Location of Death Montgomery Ac. County of Death Montgomery Ac. County of Death Montgomery Ac. County of Death Montgomery Ac. County Ac. C		Chata	•	30	11 00071
Physician Modifical Examiner Clarence Bruce Derricotte June 21, 20		Registrate Liver Laperry, 6/30/11; HWW, McCo	Sertificate of Death		11 22271
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Funeral Director Social Security Number S				4c. Coun	ty of Death
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The state of the s	Director	301-24-3304 1 M 2 □ F 82 Yrs	Months Days Hours Min	June 22, 1928	9. Birthplace (State or Foreign Country) Fostoria, OH
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A sequentially list conditions, if any, leading to time cause. Sequentially list conditions, if any, leading to time cause. Sequentially list conditions, if any, leading to time cause. Sequentially list conditions, if any, leading to time cause. Sequentially list conditions, if any, leading to time cause. Sequentially list conditions, if any, leading to time cause. Sequentially list conditions, if any, leading to time cause. Sequentially list conditions, if any, leading to time cause.	aryland a-f show fied at	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
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examiner? C	an: In tifficate for, pa		26. Place of Death (Check		1 Yes 2 No
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2 Accident 3 Suicide 4 Homicide 2 Be. Place of Injury - At home, farm, street, factory, offic	ng Ph fter th ineral	27. Manner of Death 28a. Date of injury 28b. Time	of 28c, Injury at		
4 Homicide determined 28e. Place of Injury - At nome, farm, street, factory, office 28f. Location (Street and Number or Rural Rule) building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifier Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifier 29b. Signature and title of certifier 29c. License number 29c. Licens	ttendi death ttor: A the fu	2 Accident Investigation	M 1 🗆 Yes 2 🗆 No		
29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29c.	rtal or Ar Ins after al Direction by led in by		street, factory, office		ber or Rural Route Number,
29b. Signature and title of certifier // 29c. License number 20d. Date signed (Month De	he Hosp in 24 hou he Funer pleted fil	(Check 2 Medical Examiner: On the basis of examination and/or inv	vestigation, in my opinion, death occurred at	the time, date and place, and di	ue to the cause(s) and manner stated.
and the signed (Month), be	1-1	29b. Signature and title of certifier	29c. License number	29d. Date signe	ed (Month, Day, Year)
12 Many Minera MD 62580 June 21, 20	'	rang onne m	62580	June.	21,2011
12 Many Mursh MD 62580 June 21, 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy Churosh, MD 9901 Medical Center Drive, Rockville, Maryland 20		30. Name and address of person who completed cause of death (Item 23a) (Type Nancy Churosh, MD 9901 Medical	center Drive, Rock	ville, Marylar	nd 20450
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	red.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 25 per med cert G917/15/11Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 24. 2011 Year Demetrios Diamantidis 1:15a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital Olney If Under 1 Year Months Days Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours (Month, Day, Year) 08/05/1937 73 577-54-1914 Director Egupt Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 29a-4-shw 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Maryland Montgomery Rockville 1 🗌 Yes 2 🎗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5011 Randolph Road 20852 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

X Yes 2 □ No 1957-Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White 1961 Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ches Culinary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Diamantidis Dorothea Mertzos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Diamantidis - Daughter 5011 Randolph Road, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 106/28/2011 Silver Spring, MD 21. Signature of Fune al Service Ligensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, New Hampshire Ave., Silver Spring, MD 20904 11800 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death ancer with Metastasis Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 X No 1 Yes 2 No Yes 25. Was case referred to medical To Be apleted filled in by the funeral director, 26. Place of Death (Check only one) 2 🛣 No Other: 1 Yes 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1XNatural 5 Pending s after death. I Director: Aft 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6/24/11 3+1 address of person who completed cause of death (Item 23a) (Type, Print) ince 10181 31. Date filed (Month, Day, Year, State JUN 28 2011 Registrar

			For State Registrar	State o	of Marylar	nd / Depa Cer	artment of H tificate of L	Health : Death	and M	lental Hy	giene	201		22273
П			Decedent's Name (First, Middle)	e, Last)			timoato or z		T	2. Date of Dea				3. Time of Death
	Physicia Media		Shirle	y P. Davis	S					June 1	19, Day	2011 ^{Ye}	ar 1	1:25 P M
	Examir	ner	4a. Facility Name (if not institution	, give street and num	nber)		4b. City, Town, o	r Location o	of Death		4c.	County of E	eath	
- 4-1	<u> </u>		Springbrood 5. Social Security Number	k Nursing		t that t		er Sp				Mont		
1	Funeral Director		251-76-0768	1 □ M 2 🗷 F	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birt (Month, Day Sept. I	3, Year) 1	944	Birthplac Country Sout	ce (State or Foreign h Carolina
	ind ihow	5	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loc	eation	<u> </u>					10d	. Inside City Limits
	Maryla 8a-f tified	Funeral Director	DC					Was	shing	ton				1 🔀 Yes 2 🗆 No
	a or 2 be no	ä	10e. Street and Number				10f. Zip Code	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3112118	1	10g. Citi	izen of What	Country	?
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	r deat or iten iner i	y Fu	11. Marital Status 1 ☒ Never Married 2 ☐ Mari	Armod Ea	edent Ever in U. rces?		Vas Decedent of H Yes, specify Cuba	ispanic Oriç ın, Mexican	gin? (Spec ı, Puerto F	ify Yes or No- Rican, etc.)		14. Race - A	merican /hite, etc	
920	s after ral", c	ed by	3 Widowed 4 Divorced	If Von Oil	'e	1	☐ Yes 2 🔀 No	Specify:			- [.		Blac	
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2	nin 72 ne. shan " e Me	E O	Elementary/Seconday (0-12)	st grade completed) College (1-		life. DO	ind of work done of NOT use retired)			g 				•
2	ed with	BeC	17. Father's Name (First, Middle, L	4			Accou	nting				Priv	ate	
and	be file ental I ked o c eve	2		ohn Pope						(First, Middle, . ietta V		,		
ary	should be filed with and Mental Hygien is marked other th raumatic event, the		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street a					-	Zin Coo	(a) 20005
Ξ̈́	I and 2 should be file I Health and Mental I Item 27 is marked o other traumatic eve		Colleen Brown -	- Friend		700 1	3th Stre	et NW	I Su	ite 120	00 1	Vashin	gton	DC
ore	of He of He If item or oth	1 7	20a. Method of Disposition 1	2 Pamoval from			sition (Name of natory or other plac	e)	Da	ate 2011	20c. Lo	cation - City	or Town	, State
Baltimore, Maryland 21215-0036	t. Pag tment tant: ijury o		4 Donation 5 Other (S		Citato	-	Cemetery		Ju1y	2,	New	Berry	, sc	3
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	mit:	4 / I	Name and Addres						-	nc. 0019
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that c	aused the deat								A	pproximate
~.	Physician/		Immediate Cause (Final disease or condition	•	Stage	Rena1	Disease						. 0	terval Between nset and Death Vear
	Medical Examiner		resulting in death)		or as a consequ								1	
		er	Sequentially list conditions,	b. — One trade	ur as a consequ	sanca on								
	ted J unsit	Examin	cause. Enter Underlying Cause (Disease or iinjury	Buc 15 (or do d donisequ	131103 01).								
	execu an and rial-tra	EX	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							\top	
09	te be nysicia ne bur	edical	'	d										
284	irtifica ling ph e as th		IF FEMALE:	00-16							200		-	22
Box	death certificate be executed he attending physician and ed for use as the burial-transi	cian,	23b. Was decedent pregnant in the past 12 months?			ıl death 3 🔲	Ectopic pregnanc	у			2	23d. Date of Month	delivery Da	y Year
 W	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/M	1 Yes 2 No 9 Unknown	9 Unkn		ieau 5 🗆	Other (specify)					Monar	Ба	y
O.	law requires that the nas been signed by the s 2 should be detach	by Pi	Part II. Other significant conditio	ns contributing to de	eath but not res	ulting in the ur	derlying cause giv	en in Part I.		23e. Did to	bacco us	se contribute	to the c	ause of death?
g,	quires en sig ruld be	ed k	Hypertension							1 □ Y	es 2 [□ No 3 □	Probab	ly 4 🖾 Unknown
Vital Records,	aw rec as bee 2 sho	Completed	Diabetes Mell	itus						24a. Was a		24b. Were	autopsy	findings available letion of cause of
Ž	The I	Con								perfor	med?	death	? Yes 2	
<u>ta</u>	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ce of Death	h (Check d					
<u>></u>	Phys rthis eral dir	<u>3:</u> 10	1 Yes 2 XNo 27. Manner of Death	1 🗆 I 28a. Date o	Inpatient 2 of injury	ER/Outpatient 28b. Time of	3 DOA Othe	4 🔼 Nur		e 5 Reside			ecify)	
S D	nding ath. :: Afte e fune	icate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig	g (Monti	h, Day, Year)	injury	work's	? Yes 2 □ I		od. Describe no	ow injury	occurred		
Division of	r Atte er dez rector by th	Certificate:	3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place	of Injury - At hor	me, farm, stree	et, factory, office		28	Bf. Location (St		Number or	Rural Roi	ute Number,
É	ital or urs aff ral Dir lled in								4	City or Towi				
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page.	Medical	(Check 2 L Medical Ex	Physician: To the be caminer: On the basis Nurse Practioner: T	s of examination	and/or investig	ation in my oninio	n death occ	curred at the	a time date an	d place .	and due to th	a caused	s) and manner stated.
	Vith Vith Community		29b. Signature and title of certifier				29c. License					signed (Mo		
	(1		2NAN				D286	556			Jun	e 24,	201	1
R	4		30. Name and address of person was Passi. M.D	·	,	, , , , ,	,	130	Rock	ville.	Md.	2085	50	
	Stat Registra	•	31. Date filed (Month, Day, Year) JUN 2 9 2011	32 Re	gistry 's Signa	uro				,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 200 HELEN DARLING Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death ortal stimure CYX Maryland steneral Social Security Number Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months 1 □ M 2 🙀 F Hours 02-1, 4-1948 Director 63 222-30-9231 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits or 28a-f DE SUSSEX 1 XYes 2 No GEORGETOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a by Funeral USA DUNBARTON OAKS, 19947 I, APT. 304 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. be filed within 72 hours after of 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes Give "natural", Specify. Completed 3 Widowed 4X Divorced Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Menta. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) POULTRY LINE SPECIALIST 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL WADE KINZER NELLIE VIOLET FLETCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KINZER, BOX 843. MILFORD. BARBARA DE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🙀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FIRST 7-6-11 MILLSBORO, DE STATE CREM. Signature of Funeral Service Licensee 22. Name and Address of Facility SHORT FUNERAL SERVICES m hit 609 ST. \mathbf{F} MARKET GEORGETOWN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic Physician, disease or condition resulting in death) Medical Examiner tering Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consquence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day the 9 Unknown 9 Unknown funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending injury s after deu seral Director; Ar filled in by the Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a

To the Funeral D

completed filled i Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Prantioner To the best of my knowledge, draft undured at the time, date and plane, and due to the cause(s) and manner as state. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) House officer. Smy 0 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Walter Elseroad J. 2011 19. June 8:10p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 □ F 93 Director 217-36-4189 11/3/1917 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examinat must be notified at 1 Yes 2 □ No Completed by Funeral Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or item or or other traumatic event, Itw Medical Examination must be not 4210 Crystal Court 2B 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No white Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent golf club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Elseroad Myrtle Beatley ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth A. Rill, stepdaughter 312 Blue Grass Lane, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Surial 2 ☐ Cremation 3 Na Removal from State St. David's UCC Cem. 6/25/2011 Hanover, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home M00741 934 S. Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Beath **Physician** resulting in death) /Medical **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-trans P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a detached f ☐Yes 2 ☐ No 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 km/No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

rond

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 22

Westminster

d address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 Lucile Erdreich June 10:28 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Eden Group Homes Montgomery Bethesda Social Security Number 8. Date of Birth De^{(Month}5^{Day, YP}911 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Min. NewyYork 1 🗆 M 2 😾 F 99 Days Hours 116-34-7715 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Potomac Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20854 USA 10113 Ormond Road Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theresa Eichberg Fred Lehman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10113 Ormond Road, Potomac, Maryland 20854 Joan Kotz/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place.
Vassar Temple Cem. 1 Surial 2 Cremation 3 Removal from State 6/26/2011 Poughkeepsie, New York 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 mo1597 MCG LEEN HUST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Atrial Fibrillation Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Valvular Heart Disease Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dysphagia 1 Yes 2 No 3 Probably 4 Qunknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) Living examiner? Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician Medical Examiner Exami

Physician/

Medical

Examiner

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injury or other traumatic .. Page 1 and 2 should by tment of Health and Mer tant: If item 27 is mark

Department of H Important: If ites any injury or oth once.

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Baltimore, Maryland 21215-0036

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burial-transit and attending physician law requires that the death certificate be the use as signed by the aid be detached for peen page 2 has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h funeral director, filled in by the

P.O. Box 68760

Division of Vital Records,

Physician/Medical

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Completed

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Certificate:

Medical

29a. Certifier

(Check only one)

27. Manner of Death 1 X Natural 5 Pending Accident

6 Could not be Suicide 4 Homicide determined

28a. Date of injury (Month, Day, Year) Investigation

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at iniury

1 Ves 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated operatifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title

29c. License number D35579

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8218 Wisconsin Avenue, Suite 305, Bethesda, Maryland 20814 Susan J. Miller, MD

State Registrar

сотріете

31. Date filed (Month, Day, Year) IIIN 28



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 Physician/ William Howard Engelhart 022/AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner licomico imail Madical Cente 10 If Under 1 Year If Under 24 8. Date of Birth 9. Birthplace (State or Foreign 3irthpia Country) York **Funeral** Days 04/10/1929 126-20-4842 82 New Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Virginia Melfa Accomack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28404 Yeo Neck Run 23410 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Armv 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Rhoades Howard William Engelhart 19a. Informant's Name/Relationship (Type, Print)
Margaret M. Engelhart/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28404 Yeo Neck run, Melfa, VA 23410 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairview Lawn Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 6/24/2011 Onancock, VA 4 ☐ Donation 5 ☐ Other (Specify) Holloway Fuheral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Sign turn of Funeral Servix Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Du to or as a conseque e of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	For AMEND#2, 29D Pear PHYSTATE OF MARYLAND 7 D 1 - State 6/23/2011 AACO HEALTH DEPT CMH	Certificate of E			eg. Noo O I I	00070
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Deat		5. Time or Death
	Medic Examin	al	Dean C Ferris 4a. Facility Name (if not institution, give street and number)	4b. City. Town, or	Location of Death	Month 06	17 -200	+ 10:12 PM
!			Anne Arundel Medical Center	Annapo.	lis		4c. County of Dea Anne Ar	
	Funeral Director		5. Social Security Number 185-14-5927 6. Sex 1 🕅 M 2 🗆 F 91 Vsual Residence of Decedent	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 24,	Year) 9. Bit Co	rthplace (State or Foreign ountry) nnsylvania
	faryland Ba-f show tified at	Director	10a. State 10b. County 10c. City, Town of Arne Arundel Arnol					10d. Inside City Limits 1 ☐ Yes 2 ※ No
	with the N s 23a or 2 ust be no	Funeral Di	10e. Street and Number 1003 Via Amorosa	10f. Zip Code 2101	2	1	0g. Citizen of What C	ountry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 🖫 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1941 − 1 ☒ Yes 2 □ No 1946 If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	vithin 72 hou iene. ir than "natu the Medical	Completed	(Specify only highest grade completed) (Decedent's Usual Occupi Give kind of work done of ife. DO NOT use retired) Engineer	ation during most of worki	ng	16b. Kind of Business Westingho	
land ?	should be filed whand Mental Hyg h and Mental Hyg 7 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last) Ralph Elijah Ferris		18. Mother's Name Olive Ho			
, Mary	id 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Edna T. Ferris / Wife 10	Mailing Address (Street a	and Number or Rura	Route Number,	City or Town, State, Z 21012	ip Code)
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		t Rurial 2 V Cramation 3 Removal from State cemetery	Disposition (Name of t, crematory or other place Crematory,	INC June	Date 20,	20c. Location - City of Baltimore	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	Parranco & 495 Ritchi	Sons, Pacility Sons, Pacility	.A. Seve Seve	rna Park F rna Park,	uneral Home MD 21146
P	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	hock d		r respiratory arre	st,	Approximate Interval Between Onset and Death
	Medical Examiner	je.	resulting in death) Due to (or as a consequence of, Sequentially list conditions, b.	,				
	and transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence					
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Box	ne death certific / the attending ched for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	ey		23d. Date of de Month	elivery Day Year
ls, P.O.	to the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	ed by Pl	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	ven in Part I.	23e. Did tob	es 2 No 3 F	o the cause of death? Probably 4 🗹 Unknown
Division of Vital Records,	sician: The law req s certificate has bee lirector, page 2 shou	Completed by				24a. Was ar autops perforr 1 \sum Yes	ned? death?	utopsy findings available completion of cause of
ta	ician: I sertifica ector, p	Be	25. Was case referred to medical examiner?	26. Pla	ace of Death (Check		1101	
of V	g Phys er this eral dir	te: To	1 Yes 2 No 1 Inpatient 2 ER/Outs 27. Manner of Death 28a. Date of injury (Month, Day, Year) inj	patient 3 L DOA	4 ∐ Nursing Ho ⁄at		ence 6 Other (Sper w injury occurred	cify)
ion	ttendin death. :tor: Aft / the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 🗆	Yes 2 No	20f Leastien (St	reet and Number or Ru	und Pauta Mumbar
	tal or A rs after al Direct ed in by		4 Homicide determined 28e. Place of righty - At Home, fam. building, etc. (Specify)	n, stroot, lastery, emice		City or Town		and Houte Wallbor,
	he Hospi in 24 hou he Funer spleted fill	Medical	29a. Certifier (Check conly one) 1 ■ Certifying Physician: To the best of my knowledge, decomply one) 2 ■ Medical Examiner: On the basis of examination and/or only one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 1 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 2 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 3 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my knowledge, decomply one) 4 ■ Certifying Nurse Practioner: To the best of my k	investigation, in my opinio	on, death occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.
			29b. Signature and title of certifier	29c. License	6465	2	9d. Date signed (Mont	th, Day, Year) 2011 2001
	150		30. Name and address of person who completed cause of death (Item 23a) (Ty	ype, Print) ROOI Medi	cal Protu	Jay Ann	abolis	MD 21401
	Stat Registra		31. Date filed (Month, Day, Year) JUN 2 3 2011 32. Registrar's Signature	harles	- 100(K)	1 11414	0.123	, , , , , , , , , , , , , , , , , , , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Phyllis Gale Fisher 201 une Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico is buru Rehabilitation & Nursing Ctr lisbury Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 88 Yrs. Funeral 369-18-2070 Months Hours Min. 0271371923 Michigan Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director 1 Yes 2 No 28a-f Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? it. Page 1 and 2 should be filed within 72 hours after death with the rtment of Health and Mental Hygiene.

rtant: If item 27 is marked other than "natural", or items 23a or niury or other traumatic event, the Medical Examiner must be I Funeral 1707 Eastgate Village, Apt. 308 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 K Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Louis Rolle Carpenter Sylvia Mae Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 S. Camden Ave., Fruitland, MD 21826 19a. Informant's Name/Relationship (Type, Print) Kristy Parker/Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parsons Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/2011 Salisbury, MD 4 Donation 5 Other (Specify) Signa ure of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Den Imo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ , ear Ton disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Oan. and resulting in death) Last (of as a consequence of) been signed by the attending physician Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner' Other 2 400 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. JUN 23

am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins

gistrar's Signature

		1 - State of Mai		artment of Health and I <i>tificate of Death</i>	Mental Hygier Reg.		
Physic	ian/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Med Exam	lical	Helen M. Fielding 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death	6 20	2011 4c. County of Death	12:10P ^M
LAGIII	IIICI	Southern Maryland Hosp		Clinton		P.G.	
Funera Directo			(In yrs. last birthday) 69 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 1 - 1 - 1 9	r) Coun	place (State or Foreign try) Wash,
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with the same same same same same same same sam	Funeral	4210 Torque St.		20743	109.	U.S.A	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Event Armed Forces? 1 □ Yes 2 ☒ No. If Yes, Give Year or Dates.	. If	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, e Specify: B1	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of any lajury or other traumatic event, the Medical Examinary in the medical Examination.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupation kind of work done during most of work D NOT use retired) Clerk	king	. Kind of Business Ind Governme	,
rland 2 t be filed w Mental Hygi rrked othe	To Be	17. Father's Name (First, Middle, Last) Mason Liddell			ne (First, Middle, Maide 1 Mack	en Surname)	
Mary of 2 should saith and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Daugh Angela Fielding	ter 19b. Mailin	g Address (Street and Number or Rui Torque St. Ca			
imore. Page 1 an ment of He tant: If iten lury or oth		20a. Method of Disposition 1	Lincoln	Mem"1 Cem.	7-2011 Su	Location - City or To litland N	wn, State 1D •
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee Francis B. Hunt	9	Name and Address of Facility Hu 08 Kennedy St.	nt Funer N.W. Wa	al Home sh, D.C.	20011
41387		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	he death. Do not ente	r the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Ph sician Medica Examine		disease or condition resulting in death) a. Due to (or as a condition)	onsequence of):	olo DeCas	lita	00	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):	1606 5/8	(20)		
760 icate be executed physician and sthe burial-transit	Examiner	Cause (Disease or iinjury that initiated events c.	consequence of):	V - /			
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Box 68 death certif the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Nub 2 □ Unknown 23c. If yes, outcome of 1 □ Live Birth 2 □ Pregnant at t □ 9 □ Unknown 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
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ivision of Vital Recc or Attending Physician: The law after death. Director: After this certificate has d in by the funeral director, page 2	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (/ - At home, farm, stre (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
Dji To the Hospital of within 24 hours at To the Funeral D completed filled it	edical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of m	mination and/or invest	igation, in my opinion, death occurred	at the time, date and pla	ace, and due to the cau	use(s) and manner stated.
To the within To the comp	Σ	29b. Signature and title of certifier A A A A A A A A A A A A A	ley	29c. License number		Date signed (Month, I	
R 7		30. Name and address of person who completed cause of dea	th (Item 23a) (Type, P	rint) 9135 Pisch	Conteey MAN	200 TI	30
St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 9 2011 32. Registrary	Signature	eint	en my		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04780 State of Maryland / Department of Health and Mental Hygiene Reid Marshall Gilley Certificate of Death 1. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 27, 2011 0642 hrs **Medical Examiner** REID MARSHALL GILLEY 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Charles Hughesville 14800 Pale Morning Place 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Country) Days Hours Director FEB.23,1998 OK 13 445-11-3813 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No 28a-f show MD CHARLES HUGHESVILLE with the Maryland Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 14800 PALE MORNING PLACE 20637 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? hours after death 1 X Never Married 2 Married 2 X No 1 Yes Specify: 1 Yes 2 X No specify: WHITE 4 Divorced If Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Pages I and 2 should be filed within 72 h rent of Heath and Mental Hygiene.

ant: If item 27 is marked other than "a r other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 JUNIOR HIGH STUDENT 6 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RIDGE MORGAN GILLEY DEBORAH KAY BUNNING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RIDGE M. GILLEY / FATHER 14800 PALE MORNING PL., HUGHESVILLE, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State METRO - CREMATORY ALEXANDRIA, VA 2011 4 Donation 5 Other Specify 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service 800 5635 WASHINGTON AVE., LA PLATA, MD M00641 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death /Medical Immediate Cause (Final disease Seizure Disorder Examiner or condition resulting in death) Due to (or as a consequence of): b. Cerebral Palsy Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): attending physician and for use as the burial - transi The law requires that the death certificate be executed Physician/Medical \Box AMENDED 23a-b, 27, per me, g918 8-22-11 sm X UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available 24a Was an has been s prior to completion of cause of autopsy death? After this certificate has Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 Dther: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes 28c, Injury at Work? 28d. Describe how injury occurred 28a, Date of Injury (Month, Day, Yeer) 28b. Time of Injury 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined within 24 hours a

To the Funeral I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier

A Company

31. Date filed (*Month*, *Day* Yes 1 3 2011

Donna M. Vincenti, MD

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

June 27, 2011

Registrar

		For State	State of Ma	aryland					,			00000
		Registrar 1. Decedent's Name (First, Middle, Las	et)	-	Cer	tificate of	Death	7		Reg. N		22282
Physicia			51)						2. Date of De Month	Day 20,	2011	3. Time of Death
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Page Page ant: If		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1		atory or other p		06/23	/2011		-	aryland
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	ee	Joca		Name and Add						
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		1	For State Registrar	State of Maryla		rtment of			giene Reg. N2 1 1	22283
	Physicia Medic	n/	1. Decedent's Name (First, Middle, La Robert Bellar		Sr.			2. Date of De June	26 20 Pear	3. Time of Death 13:04 M
	Examin	er	la. Facility Name (if not institution, given 48852 Seaside	View Road		4b. City, Town,	e		4c. County of De	ry's
	Funeral Director		5. Social Security Number 216 26 7426 Usual Residence of Decedent	Sex 1 ☑ M 2 ☐ F 72	s. last birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Bin Min. 0 1 9 0 4	7.1°9′39	irthplace (State or Foreign ountry) MD
	aryland a-f show ified at		10a. State 10b. County MD St. Ma		City, Town or Loc Ridge	ation				10d. Inside City Limits 1 Yes 2 □ No
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215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Maryland. If the first and Maryland strong is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fun	1. Marital Status 1 Never Married 2 🛭 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 N	No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	Specify: B1	ite, etc. ack
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Acloert 6	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.	İ	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	hesapea	atory or other plake Cre	em. 7	Date 7/2/2011	20c. Location - City of Beltsvil	le, MD
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	ath certificate be executed Exam Medical Exam Medical Attention To reas as the burial-transit To reason and the burial-transit To reason	Physician/Medical Examiner	23a. Part 1. Enter the disease, or consock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a y load of the cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a cons	i dwy equence of):	opath	4	cardiac or respiratory ar	rest,	Approximate interval Between Onset and Death
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	ıysician/Med	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregna Other (specify)	ancy		23d. Date of o	lelivery Day Year
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Division of Vital Records.	he law requi te has been age 2 shoul	Completed							prior to death?	
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			30. Name and address of person who	completed cause of death (It	tem 23a) (Type, P	rint)	0060	ched l	62-	7(1)
	IB 10 Stat		B1. Date filed (Month, Day, Year)	Shun 20 32. Registrar's Sig	1035		Not	ched It	ollywood	MD 20630
	Registra	ır.	<u>JUN 28</u>	2011 Jeneur	p. 19	arke				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#29 openMD, 6/28/11; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2820A ica 1)/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** anera f Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** (Month, Day, Months Country) 214-78-0528 Itali Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10c. City, Town or Location Maryland Silver Spring 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15115 Interlachen Drive, 20906 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pietro Satti Giuditta Scodelaro r Health an n 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Farrell - Daughter Page 1 and 2 s 3165 Doebrook, Rd., Collegeville. PA 19426 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ō Important: If it any injury or o 1 XI Burial 2 Cremation 3 Removal from State **Department** Gate of Heaven Cem. 07/01/2011 Silver Spring, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licensee 1800 New Hampshire Ave., Silver Spring. 23a. Part 1. Enter the disease mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Lis ne cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cons ath certing...
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...o as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Dav Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perfor death? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number**D - 66793** 29b. Signature ar who completed cause of death (Item 23a) (Type, Print) ernwood OZIS 31. Date filed (Month, Day, Year) State JUN 2 8 2011

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 Day 201 Tar June Go1ub 11:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 604 Bennington Drive Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 83 Days Hours 1 XM 2 F Months April Day, Year) 928 NY Director 101-20-5021 Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 604 Bennington Drive 20910 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. δ 1 Never Married 2 Married 2 NO Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced WWII era Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Director Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lena Metz Julius Golub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Golub/Wife 604 Bennington Drive, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State June 28, 2011 Norbeck Memorial Park Olney, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Francis degrees of Family ins Funeral 500 University Blvd. W., S al Home Inc. Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Idiopathic Pulmonary Fibrosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

When the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-<u>transit</u> Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2XXXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 XX 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗓 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) June 27, 2011 MD18496 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Read, MD 3800 Reservoir Road, NW, Washington, DC 20007 31. Date filed (Month, Day, Year) State

Registrar

JUN 2 8 2011

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and a	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea			County of Death		
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	Funeral Director		213-32-7689	M 2DTE	95 (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Coui	place (State ntry) SC	_
	and w] }	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside C	ity Limits
	the Maryl 28a-f sho lotified a	Director	MD Baltim	ore		White	Hall		10a Citi	izen of What Cour		2 X No
	with with the rate of the rate	i	20825 West L	iborty B	o a d		1161			J.S.A.	,	
	ms 2%	Funeral	11. Marital Status	12. Was Decedent E		3. Was Decedent of I If Yes, specify Cub		Specify Yes or N		14. Race - Americ		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Martel Framiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Armed Forces? 1 □Xes 2 □ N If Yes, Give Year or Dates:	1845-	1 ☐ Yes 2 XNo		rto Hican, etc.)		Black, White,	^{etc.} White	
5-0	72 ho 'natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	cedent's Usual Occu ve kind of work done	during most of wo	orking	16b. Ki	nd of Business/In	dustry	
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7	filed withir Hygiene. other than		17. Father's Name (First, Middle, Last)	3		Nurse	1	ame (First, Middle		ealth Co Surname)	are	
an	be d a	To Be	John F. Pettit					L. Bal				
ary	d 2 should th and Mer 7 Is marke traumatic	-	19a. Informant's Name/Relationship (7		19b. Ma	iling Address (Stree					o Code)	
	nd 2 alth a 27 L		Roberta S. Dec	ker/Daug	hter 208	325 West	Libert	y Rd.				21161
ore	of Heals of Heals if item 2		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Dis	position (Name of ematory or other pla ION DITE	^(ce) ± Ju	Ly 8,	20c. Lo	ocation - City or To	own, State	
Ĕ	nit. Pag artment ortant: I injury c		4 ☐ Donation 5 ☐ Other (Specify)	Servic		20		<u> </u>	ork, P	Α	
Baltimore,	permit. Pages 'Department of Important: If ite any injury or of once,		21. Signature of Funeral Service-Licen			22. Name and Addr L9 S. Ma						
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not e	enter the mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approxima Interval Be	te etween
4	Physician		Immediate Cause (Final disease or condition	а.	con	gestive	HEART	Failu	170		Onset and	tars
1	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	gestive / Fibri	11 -1		(.		10-	
н	LAGIIIIICI	<u></u>	Sequentially list conditions,	b	ATCI3 a consequence of):	FIBCI	1/2710h	-		-	10 y t	ars.
	nted I nsit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence or).							
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99	# go #	Medi	IF FEMALE:									
Вох	eath cer attendir for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth		B ☐ Ectopic pregnan	су			23d. Date of deliv Month	ery Day	Year
0.	the a	/sici	1 ☐Yes 2 ☑No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify)				Monar	Day	1001
Э.	that the de ned by the a detached f		Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco u	use contribute to	the cause of	death?
ds,	w requires to been signer should be a	d by		Ü				1 🗆	Yes 2	□ No 3□ Pro	bably 4	Unknown
Vital Records,	w req	Completed				-		24a. Wa	s an	24b. Were auto	opsy findings	available
æ	The law cate has page 2 :	ᇤ						- auto	opsy formed?	prior to co	ompletion of	cause of
		Be C	25. Was case referred to medical				26. Place of De	1 ∐Yes eath (Check only		1 □Yes	2 No	
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0	ng Pr fter th meral	L:uc	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Da)	ry 28b. Time		ury at ork?	28d. Describe	how injur	ry occurred		
Sio	Attending r death. sctor: After by the fune	catic	2 ☐ Accident investigation			M 1 []Yes 2 □No					
Division of	To the Hospital or Attending Physwithin 25 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	iry - At home, farm, c. (Specify)	street, factory, office			(Street ar own, State	nd Number or Rui e)	ral Route Nu	mber,
	ne Hospi n 24 hou ne Funer sletely fill	Medical	29a. Certifier (Check only one) Check only one) Certifying Ph Certifying Ph Certifying Ph	ysician: To the best on hiner: On the basis of and manner sta	examination and/o	ath occurred at the investigation, in my	time, date and pla opinion, death oc	ice, and due to th curred at the time	ne cause(s e, date an	s) and manner as d place, and due	stated. to the cause	(s)
	To the within To the COTTING C	M	29b. Signature and title of certifier				se number	()		ite signed (Month		
	1 25		den Sm	ran My		D5.	3156	(MD)		7.6.11		
	PX. P		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print) Soft Ad	an hI	Cach	Plase	1/10.10	A 2/	230
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	>011 Hd	917 114	LUCK	7	THE THE	J	~~
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ORIGINAL

			101	tate of Marylar				and Mental Hy	giene	
			State Registrar		Cen	tificate o	f Death		Reg. No	22287
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	3. Time of Death
and the same	Medic	al	Paul D. Gordy, Sr. 4a. Facility Name (if not institution, give stree			4h Cih Tour	ı, or Location o	Death OG		
	Examin	er		At the	ake		isbur	Death	4c. County of De	em (Co
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs. I		If Under 1 Ye	ar I If Under 2		th g. B	irthplace (State or Foreign
	Director		214-30-8420 1 M	2 L F	77 Yrs.	Months Day	ys Hours	Min. (Month, Da Aug. 23	, 1933 I	laryland
A)	how at	_	Usual Residence of Decedent 10a. State 10b. County	10c, Cit	y, Town or Loc	ation				10d. Inside City Limits
	arylar la-f s	Director	MD Worceste		ow Hil					1 ☐ Yes 2 🖾 No
	the M or 28 e not	ğ	10e. Street and Number	1 31	IOW IIII	10f. Zip Cod	le		10g. Citizen of What 0	Country?
	s 23a	Funeral	3910 W. Hills Drive	2		21	.863		U.S.A.	
	death item ner m	Fur		Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent o	of Hispanic Orig uban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite etc.
36	after al", or xami	d by	1 Never Married 2 Married	1 $\overline{\mathbf{X}}$ Yes 2 \square No $\overline{1}$ If Yes, Give	152-1	☐ Yes 2 🏋			Specify:	white
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Gorette Maryland	should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Walter D. Gordy					r's Name <i>(First, Middl</i> e, la Cotti ngh		
3 2	ould k nd Me mark matik	Ĺ	19a. Informant's Name/Relationship (Type, F	Print)	19h Mailine	n Address (Stre		r or Rural Route Numbe		Zin Code)
\(\sigma\) \(\Sigma\)	d 2 sh alth ar 27 is or trau		Anna Gordy (Wife)	ŕ	1		s Driv			863
ore,	of Hear of Hear fitem		20a. Method of Disposition		Place of Dispos	sition (Name of	olace)	Date	20c. Location - City	or Town, State
1 i	Page ment ant: I		1 Burial 2 ☐ Cremation 3 ☐ Rem Donation 5 ☐ Other (Specify)	oval Ilolli State	es Memo			6-22-2011	Snow Hill	, Maryland
Paul D	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	10	1		dress of Facility	DHOIC IG	neral Home	
	ED = 60		23a. Part 1. Enter the disease, or complicati	-/ / V					1mar, DE	
			shock, or heart failure. List only one ca	use on each line.	A<		iying, such as t	sardiac of respiratory ar	iest,	Approximate Interval Between Onset and Death
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	_ +	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent	uence of):					
	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequ	ionos ofi:					
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Box 687	death ne atte ed for	Physician/Me	1 Ves 2 No	4 Pregnant at time of a		Other (specify,			Month	Day Year
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Division of Vital Records,	afor A after Direct		4 Homicide determined	building, etc. (Specify	<i>(</i>)	ot, lactory, ome		City or Tov		idra Fiorce Number,
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician	: To the best of my know	ledge, death o	ccured at the ti	ime, date and p	place, and due to the ca	use(s) and manner as	stated. e cause(s) and manner stated.
	the H hin 24 the Fu trplete		only one) 3 Certifying Nurse Pra			eath occurred a	t the time, date		e cause(s) and manner	as stated.
	vit vit		29b. Signature and title of certifier	1 1	111	29c. Lice	ense number		29d. Date signed (Mor	ntn, Day, Year)
	E		30, Name and address of person who compl	eted cause of death (Itam	100 D	int)	3031)		9/1///	
	11/18		M. IHIMMARAYINPA	910 E	15/ER	v SDI	RE DR	L SALLS	BURY M	1) 2/804
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		1	State of Maryland / Department of Health and Mental Hyglene State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No. 2011 1 2 2 2 2 3
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year OLE 2.7 John Day Year OLE Day Year OLE Day Year OLE Day Year OLE Day Year
and the same	Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year of Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month Day Year)
	Director		210-22-3160 1 M 2 F P4 Yrs. Months Days Hours Min. (Month, Day, Year) Pennsylvania Usual Residence of Decedent
	Maryland 8a-f shov Atified at	rector	10a. State Montgomery
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 4118 Mitscher Court 10f. Zip Code 20895 10g. Citizen of What Country? U.S.A.
900	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	É	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Yes, Specify Yes or No-If Yes, Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 18. Race - American Indian, Black, White, etc. 19. Yes, Specify Yes or No-If Yes, Specify Yes, Specify Yes or No-If Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes,
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) The memaker 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker
1212	led within Hygiene. other thai ent, the N	as l	Homemaker 12 Homemaker Homemaker 18. Mother's Name (First, Middle, Maiden Surname)
/lanc	should be file n and Mental H 7 is marked o raumatic eve	입	James Collins Anna Murphy
	Sh har 7 is trau		19a. Informant's Name/Relationship (Type, Print) James J. Gorman - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4118 Mitscher Court Kensington, Md.20895
Baltimore,	Page 1 nent of ant: If ii ary or c		20a. Method of Disposition 1
Balti	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wash., D.C. 20001 Robinson Funeral Home 1313 6th St.NW
	h sician/ Medical Examiner	ner	23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease as including to immediate cause).
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Division of Vital	i ji g	Cert	3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Could not be determined determined 5 Could not be determined 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 7 City or Town, State) 7 City or Town, State)
	Hos Pun Fun	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the within 7 to the comple	Σ	only one) 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 / RUSSELL FUEIUUE
1	Sta	te.	14, RUBERT BIRSCHBALLHULD GALTHELSBURG MA 20847 31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 9 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		ai yidi ii	_	tificat				Reg. N	20		222	289
Physicia		1. Decedent's Name (First, Middle, Last) Teresa G. Hale							2. Date of D Month		ay 5 2	Year 2 0 1 1	3. Time of 4:15	
Medic Examin		4a. Facility Name (if not institution, give st	reet and number)			4b. City,	Town, or	Location of Dea	<u> June</u>		c. County		14.13	
		2801 Brewster R	oad				aldo				Char	les		
Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age	(In yrs. Ia 81	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min		irth ay, Year)		g. Birthp Coun	olace (State o try) Ital	r Foreign
		Usual Residence of Decedent		01					1 3/10	/ 19.	30 [1001	- <u>y</u>
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should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me		19a. Informant's Name/Relationship (Type			19b. Mailin	g Address	(Street ar		(Unknov ural Route Numb		r Town, S	tate, Zip C	ode)	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re	emoval from State	Ce	ace of Dispos metery, crem	natory or o	ther place		Date	1		City or To		
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permit. Departr Importa any inju		Kimirlu Im	SCO0 11	nu					gton F					0601
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 X Certifying Physici	an: To the best of n	ny knowle	dge, death o	ccured at	the time, o	date and place,	and due to the ca	ause(s) a	nd manne	er as stated	d.	
the Ho hin 24 the Fu	— r	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	r: On the basis of exp Practioner: To the b	est of my	and/or investi knowledge, d	gation, in neath occur	ny opinion red at the	, death occurred time, date and pl	at the time, date ace, and due to th	and place ne cause(e, and due s) and ma	to the cau nner as sta	se(s) and mar ted.	ner stated
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200	-	30. Name and address of person who com	pleted cause of de	ath (Item 2	23a) (Type. Pr	int) ~	16	, , , ,		00	10 2	-	7, 21 2068	
253		Y-WISOTSKY A	U.n. 126	270	04)	LAUE	CE	WER	WALK	KF	KA	d.	206€	2
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2011 22290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Helen Irene Harris June 4:05 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3723 Pecan Court Charles Waldorf Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 💢 F Months Hours December 4, 1949 County land Director 219-56-0509 61 Usual Residence of Decedent 28a-f show 10h County 10a State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Charles Waldorf ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 3723 Pecan Court 20602 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 N No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. ö 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) Prince Georges Co. College (1-4 or 5+) 12th. Supervisor Permits Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucille Nalley James E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Michael F. Harris/ Husband</u> <u>3723 Pecan Court.</u> Waldorf, Maryland 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 27, 2011 Waldorf, Maryland Huntt Crematory 21. Signature of Figure Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or Immediate Cause (Final Matastatic Small Cell Cancer Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Insulin that the death certificate be executed dependent that initiated events resulting in death) Last physician a the burial-t Physician/Medical Box 68760 attending pl IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown the a 9 Unknown P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural iniury 5 Pending work' 1 Tyes 2 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0057999 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 284 Terrace Drive Ste 103 Jariwala. MD 11637

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 06 2011 Bertha Marie Haines 10:30 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 665 Geneva Drive Westminster Carroll Birthplace (State or Foreign Country)
 MD Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, av 3 1 M 2 X F Months Days Min. 86 220-18-0076 **Director** May Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho her must be notified at 10c. City. Town or Location 10d, Inside City Limits Director 1 Tes 2X No MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 519 Old Baltimore Road 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Factory worker Westminster Knit any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Upton E. Myers, Sr. Mary Etta Petry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health ar Important: If item 27 is Wilbur E. Haines/Husband 519 Old Baltimore Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State Pleasant Valley Cem. 06/20/2011 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nding p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed orders discort .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SON s home ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 20052763 6/17/11 Ernesto M. Mendoza, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 22292 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6 Arlene A. Hess 9:50 PM 2ˈ0ˈ11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 906 Wedgewood Terrace Westminster Carroll Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Hours 181-26-9974 76 Director 2*/1*14/1935 Usual Residence of Deceden or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Wedgewood Terrace 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Narried 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Specify. white event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Co-Pastor Ministry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Kramer Miriam Mengel traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158Department of Health a Important: If item 27 is any injury or other trau William R. Hess - Husband 906 Wedgewood Terrace Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 ី Removal from State Carmel Cemetery 6/21/11 4 Donation 5 Other (Specify) Littlestown, PA 21. Signature of Funeral Service Licens 22. Name and Address of Facility ittle's F.H. 34 Maple Ave. Littlestown, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ardio disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events and Due to (or as a consequence resulting in death) Last attending physician To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Vear Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 N this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) If Director, After this id in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 24 hours after death. Funeral Director; Al 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Loung 210

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month Day, Year)

JUN 20

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Marie V. Holley Month 9:30 P 26 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Calvert. Prince Frederick 8. Date of Birth (Month, Day, Ye April 10, 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Washington DC Director 577 50 9860 73 Usual Residence of Decedent show 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2XX No Maryland Anne Arundel Laurel 10e, Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 55 South Bruce Street 20724 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Yes 2 XXNo Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X lNo Specify: If Yes, Give 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) State of MD Certified Nursing Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic eve once. ൧ Martin Luther Sanford Madeline Slausser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Anne Craddock (daughter) 16964 Rivers Reach Lane, Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Clinton, MD Resurrection Cemetery July 1, 2011 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria 20015 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Advanced Chronic Obstructive Pulomary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia, History of congestive Heart Failure, 2 No 3 Probably 4 Unknown 1 XX Yes 24b. Were autopsy findings available prior to completion of cause of History of colon cancer, Oxygen Dependent 24a. Was an autopsy death? ☐ Yes 2 🗓 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA |요 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural Accident iniury 5 Pendina Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one); 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

7285

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Reves,

0

9811 Mallard Drive Suite 205, Laurel, MD 20708

gistrar's Signature

D0029671

June 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 2011 1614 P M Medical EILEEN BARTON HOGAN 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL ANNAPOLIS <u>ANNE ARIINDEL MEDICAL CENTER</u> 7. Age (In yrs. last birthdav. Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 07/19/1947 Days 1 M 2X F NEW YORK Director 110-38-0223 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2X No MARYLAND ANNE ARUNDEL ARNOLD 10f. Zip Code 10a. Citizen of What Country? Funeral 626 JUPITER HILLS COURT USA 21012 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ 2 **X**No 1 Yes
If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE "natural", 3 Widowed 4 XDivorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) DIRECTOR NON-PROFIT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should e filed and Mental H ris marked of ပ RITA MURPHY CHARLES BARTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 6737 16 TERRACE NORTH, ST. PETERSBURG, FL 33710 DANIEL MURPHY HOGAN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date p rmit. Page 1 a Department of H Important: If ite any injury or ot CHESAPEAKE CREMATION CENTER 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/26/2011 STEVENSVILLE, MD 21. Signature of Funeral Service L 22. Name and Address of Facility I ASTING TRIBUTES HELFENBEIN & NEWNAM CREMATION & P.A. 814 BESTGATE ROAD, ANNAPOLI 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the magnetic state of the death. such as cardiac or respiratory arrest shock, or heart failure. List only ne cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to or as a con viquence of): Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or impury that in the later of the la Due to (or as a consequence of, attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Unknown by signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law performed' 1 Tyes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 T No ပ္ 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 No ural work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: A pleted filled in by the fu ccident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasis or examination and on investigation, in my opinion, seath about the pasis or examination and only investigation, in my opinion, seath about the pasis or examination and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

110 State

Box 68760

P.O.

Records.

Division of Vital

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of

30. Name and address of per

7 2011

31. Date filed (Month,

eause of death (Item 23a) (Type, Print)

Registrar's Signature

29d. Date sign

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, Physician/ $\mathtt{June}^{\mathtt{Month}}$ Harriet Kellerman Hartman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Vantage House Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Jan. Day 9 Months Hours Min. 1 □ M 2 🗗 New York 1922**,** 103-12-1193 89 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10a. State Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 Vantage Road 21044 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏝 No Specify. Specify: Completed 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Bookkeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Kellerman Betty Abrams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 Ronald Hartman - Son 6408 Summer Sunrise Drive, Columbia, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Maimonides Cem. 6/27/2011 Elmont, New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilianzansky-Goldberg Memorial Chapels Signature of Funeral Service Licenses Maqueenhood 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Artery Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ie attending physician and Examir The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for 5 Other (specify) Month Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Nother Specific House 1 🗌 Yes 2 XNo ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 🛚 Natural 5 Pending Division thin 24 hours after death.

the Funeral Director: Aimpleted filled in by the fu 2 🗌 No ☐ Accident ☐ Sulcide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 06/25/2011 29b. Signature and title of certifie D60628 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Esther Oh, MD 5505 Hopkins Bayview Circle, Baltimore, Maryland 20901

10:25 AM

10d. Inside City Limits

White

Approximate Interval Between 9nsered Pesth

Day

Year

1 K Yes 2 No

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 8 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22296 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty A. Hall 01:48A M do 16 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice at the Wicomico Dastai Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 💆 F Months Days Hours Min. 8-2-1949 218-48-5907 Director 61 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 No MDWicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 147 Davis Street 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married जिस्त्र A. Hall Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates speBalack 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bus VA Council of Churche Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>Jesse L. Hammond</u> Mary Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Field/Brother Delaware Avenue, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) James UM Cem 6-24-2011 Pocomoke, MD Bennie Address of Earling 917 W. Isabella St. 21. Signature of Funeral Service Lie Funeral Home Salisbury, 23a. Part 1 there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest smock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COLON CARCINOUA MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Dile to für as a consequence of, resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each bours after death.
 Funeral Director: After this certificate has been signed by the attending physicia eted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the only one) 29b. Signature and title of certifier 31C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Harry WAM 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar 22297 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year GLORIA MARION MOSLEY HART 515PM JUNE 301 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stor albot at Easto Memoria Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 79 Months Days Hours Min. 138-26-3054 DE L°XWARE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits EASTON 1 X Yes 2 □ No Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 610 Dutchman's Lane 21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Amer Negro 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Mail RCA Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELMER L. MOSLEY HAZEL I. CARNEY 19a. Informant's Name/Relationship (Type, Print, ROBERT F. HART/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Laurel Road Yeadon, PA 19050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State John Wesley Cem 4 Donation 5 Other (Specify) 6/18/2011 Milford Neck, 21. Signature of Funeral Service License 22. Name and Address of Facility MILLER FUNERAL Way Lewes, DE 19 Autumnwood 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Due to (or as a con equence of): ear disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter of denying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

201

1 ☐ Yes 2 ☐ No

Ph_sician/ Medical Examiner

Examine

Physician/Medical

Completed by

Be

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Certificate:

Medical

29a. Certifier

(Check only one)

Physician/

Medical

Director

Funeral

þ

Completed

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

107.0

the attending physician and hed for use as the burial-trans n signed by tl Id be detach⊌ is certificate has been si director, page 2 should Director: After this in by the funeral dir

24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 100 Hospital: Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

OTE

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DENNIS M. DESHIELDS 219 S. Washington St Easton, MD 21601

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

JUN 2 1

State

Registrar

within 24 hours aff

To the Funeral Di

completed filled in

		Plea	se Type or Pri	i nt in Black l aryland / Dep			-		_	
	•	For State Registrar			ertificate of L		-	Reg. No.		22298
Physicia Medio		1. Decedent's Name (First, Middle, Phoebe	Lorraine		Harris		2. Date of De Month 6	17 ^{pay}	2011 T	3. Time of Death 19:26 AM
Examin	er	4a. Facility Name (if not institution, Atlantic Genera				r Location of Death erlin		4c. C	County of Death Worce	
Funeral Director				ge (In yrs. last birthday,			8. Date of Bir 9-4-19	th 30	9. Birtl	hplace (State or Foreign intry) hington, DC
ind show at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Important: If Temp 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		cester	Berli	n					1 ☐ Yes 2 💢 No
ith the 23a or st be n	ralD	10e. Street and Number			10f. Zip Code	01011		10g. Citize	en of What Co USA	untry?
eath w tems 2 er mus	Fune	273 Ocean Parkw	12. Was Decedent B		. Was Decedent of H	21811 ispanic Origin? (Spe	ecify Yes or No-	14	4. Race - Amer	
after d	þ	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	If Yes, specify Cuba 1 ☐ Yes 2 🙀 No		HICAN, etc.)	S	Black, White becify: Wh	, etc. Lite
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illed wi Il Hygie I other vent, ti	Be	12 17. Father's Name (First, Middle, L	ast)	1	Homema	18. Mother's Nam	e (First, Middle,	Maiden Su		Olic
Ments Ments narked	မ	Anson		Overdo	rff	Helene			Swarth	out
2 shot Ith and 27 is n traum		19a. Informant's Name/Relationsh James Harris -		- 1	lling Address (Street)					
of Head of Head fittern		20a. Method of Disposition		20b. Place of Disp		1	Date		ation - City or	
t. Page tment tant: I		1 Burial 2 X Cremation 4 Donation 5 Other (S	Specify)	Cremator	ry of Delm	narva 6-20				elaware
permi Depar Impo any in		21. Signature of Fuperal Service	icensee		22. Name and Addres					and 21804
Ph_sician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	only one cause on each line	d the death. Do not er	**					Approximate Interval Between Onset and Death
Examiner	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):						
e executed sian and urial-transit	ш	Cause (Disease of injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
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To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	ey		23	3d. Date of deli Month	very Day Year
s that the	হ	Part II. Other significant conditio	. A	_	underlying cause give	ven in Part I.				the cause of death?
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ng Phy fter this		27. Manner of Death 1 Natural 5 Pending	28a. Date of inju	ry 28b. Time		y at	28d. Describe h			
r Attendi ter death. rector; A by the fu	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	gation not be	ury - At home, farm, s		Yes 2 □ No	28f. Location (S		Number or Run	al Route Number,
spital o hours af neral Di	_		Physician: To the best of	my knowledge, death			nd due to the ca	use(s) and		
the Ho hin 24 I the Fu npletec	Medical	only one) 3 Certifying	xaminer: On the basis of e Nurse Practioner: To the	examination and/or inverse best of my knowledge	, death occurred at th	e time, date and plac	t the time, date a be, and due to th	e cause(s) a	and manner as	stated.
Norit		29b. Signature and title of certifier	_		Doo	64/2e			signed (Month,	

State Registrar

374

Berlin

mive.

and address of person who completed cause of death (Item 23a) (Type, Print)

Aut 9733 Health Way

30. Narfo and address of posterior A A + + = eshan A
31. Date filed (Month, Day, Year)

JUN 2 1 2011

Baltimore, Maryland 21215-0036

		For									and N	lental Hy	gien	e			
		= State RegistraMEND#23a-	(d)pe	erMD,7/5	/11 ; E	MW,MbC	ъ Cer	tificat	of E	Death			Reg. N	201	1	2229	99
Physicia		1. Decedent's Name <i>(First, Midd</i> Mildred	ile, Las	y Iser	1							2. Date of De Month		Day	/ear	3. Time of De	eath M
Medic Examin		4a. Facility Name (if not institution	n, give					4b. City,	Town, or	Location	of Death	June 2		2011 c. County of	Death	₿:35a	
		Manor Care						-	nesd					-		gomery	
Funeral Director		5. Social Security Number	6. Se	× □м2 x 2 F	7. Age	(In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 2/19/)	Cou	place (State or F	oreign
3 4		214-36-2813 Usual Residence of Decedent								<u> </u>		2/19/	14_		Md	•	
yland -f sho ed at	ctor	10a. State 10b. Count	У			10c. City,	Town or Loc	ation								10d. Inside City I	
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after al", or xamil	d by	1 ☐ Never Married 2 ☐ Ma 3X Widowed 4 ☐ Divorce		1 Yes	2 🗽 N	No	- 1			Specify:		i iloui i, otoly		Specify:	White,	white	
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ed witl Hygier other t	Be C	17. Father's Name (First, Middle,	Last)	4			Nui	se		10 M-AL		e (First, Middle,	14-1-4-	Medic	al_		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. In Part ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	인	Ellis Kurla										Schain	iviaidei	n Surname)			
should and N is ma		19a. Informant's Name/Relation										l Route Numbe				Code)	
and 2: lealth em 27 ther tr		Kenneth Iser	ı/So	n				Cay	- -	Ave.	Bet ——	hesda,					
age 1 ant of H		20a. Method of Disposition 1 Burial 2 Cremation	3 🗆	Removal from	State	cen	ce of Dispos netery, crem ng Dav	atory or o	e of her plac			Date		Location - C	•		
mit. Pa bartme Patan r Injury		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	License	ee e		1	22.	Name an	d Addres	s of Facilit	6/26					ch, Va.	
Per B D Ber		Jaky/	E C	dward S 00910	age	1	Pi	anzar 70 R	sky ockv	Gold ille	berg Pike	Memoria Rock	al (vil	Chapel le, Md	s, . 2	Inc. 0852	_
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Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_	a. Aspi	rat:	ion Pr	neumor	nia							_	Onset and Dea	ıth ———
Examiner						consequent to T1											
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requires that the de been signed by the should be detached	y P	Part II. Other significant conditi					ing in the un	derlying c	ause giv	en in Part I		23e. Did to	obacco	use contribu	ıte to t	ne cause of deat	h?
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tendir leath. tor: Af the fu	Certificate:	1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Coulc	igation					М		Yes 2 🗆	No						
after of Direct In by	Cer	4 Homicide determ				y - At home (Specify)	e, farm, stree	et, factory,	office		2	28f. Location (S City or Tow			r Rura	Route Number,	
ospita hours uneral ed filled	Medical	29a. Certifier 1 🙀 Certifyin	g Physi	cian: To the b	est of m	y knowled	ge, death o	cured at t	ne time,	date and p	olace, and	due to the car	use(s) a	and manner a	ıs state	·d.	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transf	Me	only one) 3 L Certifyin	g Nurse	er: On the base Practioner:	is of exa To the be	est of my kr	na/or investiç nowledge, de	ath occur	ed at the	time, date	curred at and place	e, and due to the	e cause	(s) and mann	er as st		r stated.
25		29b. Signature and title of certifie	er 	Voit	20	M	1.	29c.	License D	number 2027	74			ate signed (\) 23/11	Aonth,	Day, Year)	
	ŀ	30. Name and address of person	who co	ompleted caus	e of dea	ath (Item 23	Ba) (Type, Pri	nt)									
		Kirti Voh:	ra 7	710 Br	adl	ey Bl	vd.	3ethe	sda,	Md.	2081	L7					
State Registra	_	31. Date filed (Month, Day, Year) JUN 28	2011	2.R	egistrar'	s Signaturê	far	4									
				, con													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician/ Philip Ireland Ε. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dicomico Dice At the Salisburi Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗶 M 2 🗌 Months 212-30-6817 0371871933 Maryland 78 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28237 Canterbury Drive 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 X Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give Specify: White Year or Dates. Army 3 🛚 Widowed 4 🗆 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Edward G. Ireland permit. Page 1 and 2 should be to Department of Health and Ments Important: If item 27 is marked Gladys Genevieve Leges 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
28237 Canterbury Dr., Salisbury, MD 21801 Lois Sapp/Companion Baltimore, - ud 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 6/21/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence or). the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) signed by the at d be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 L 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred V Natural injury 5 \square Pending Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4:33AM

1 Yes 2 X No

Interval Between

29d. Date signed (Month, Day, Year)

within 24 hours after death.

To the Funeral Director: After this certificate has

Medical

Registrar

4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifie

determined

DHMH 17 Rev 7/2009

leted cause of death (Item 23a) (Type, Print)

rar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Christopher E Ignaceolo

		Please Type or Pri			ndelible Inhartment of H			•		•).
		1 - State Of IVI	ai yiai iu 7		tificate of D		i iu ivie		Reg. No	001	1 22301.
Physic	ian/	1. Decedent's Name (First, Middle, Last)					2	2. Date of Dea	4 lo		3. Time of Death
Med	lical	Christopher E. Ignaccol	lo					Month O G	I-Da		
Exam		4a. Facility Name (if not institution, give street and number) Coastal Hospice Wyth 5. Social Security Number 16. Sex 17. Ag	e (In yrs. last bir		4b. City, Town, or Salisk	Location of Locati		D-t (Dist		County of Dea	nico
Funera Directo		·	33	Yrs.	Months Days		Min.	B. Date of Birth (Month, Day 11/01/	(Year)	C	irthplace (State or Foreign ountry) W Jersey
rland F show	ţ		10c. City, Tow	n or Loc	ation					·	10d. Inside City Limits
e Mary r 28a-1 notifie	Direc	Maryland Somerset 10e. Street and Number	Mario	on S	tation						1 ☐ Yes 2X No
vith th	Funeral Director	27568 Crisfield Marion Ro	oad		10f. Zip Code	L838			_	izen of What C USA	country?
leath v items er mu	Fune	11. Marital Status 12. Was Decedent E Armed Forces?		13. W	Vas Decedent of His Yes, specify Cubar		n? (Specif	y Yes or No-		14. Race - Am	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed by		No		Yes 2 K No		Puerto Mit	can, etc.)		Black, Whi Specify: W	te, etc. hite
15-0	plet	15. Decedent's Education (Specify only highest grade completed)	16a	(Give k	ent's Usual Occupa ind of work done d		of working		16b. K	ind of Business	s Industry
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filed wit al Hygie d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (F	First, Middle, I			
Ylaj uld be I Ment narke natic e	욘	Emanuele Ignaccolo					en Ed				
re, Maryland 2 1 and 2 should be filed wi of Health and Mental Hygic item 27 is marked other other traumatic event, it		19a. Informant's Name/Relationship (Type, Print) Helen Ignaccolo/mother	198	2756	g Address (Street a 58 Crisfi	eld Ma	or Rural R arior	n Rd.,	City or Mar	Town, State, Z ion Sta	ip Code) ation, MD 21838
		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State	cemete	ery, crem	sition (Name of latory or other place Cremato)	e)	Dat			ocation - City o	
Baltimo permit. Page Department (Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Furferal Service Licensee	Dails				/21/			isbury	
		136	en C	50	Ol Snow H	unera. Iill Ro	I HOU	me Prof Salisbu	ess:	ional A MD 218	association 304
Pnysician Medica Examine	ı	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. MA To Due to (or as:	9.	not ente	r the mode of dying	g, such as ca	ırdiac or re	espiratory arre	est,	-	Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	У				23d. Date of de Month	elivery Day Year
S, F.O. res that the signed by it doe detach	þ	Part II. Other significant conditions contributing to death b	ut not resulting i	in the un	nderlying cause give	en in Part I.		23e. Did tol		1	o the cause of death?
Kecords, The law requires ate has been sig	Completed							24a. Was a autops perfore	n sy med2->	24b. Were at prior to death?	utopsy findings available completion of cause of
VICAL ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input in the second sec			Otho	ce of Death	(Check or	nly one)		-2	1/2 2 2
n Or v ding Phys th. After this funeral dii	cate: To	1 Yes 2 No 10 In Investigation 1 In Inpatia 27. Manner of Death 28a. Date of injunity (Month, Day) 28a. Date of injunity (Month, Day)		utpatient Time of njury	28c. Injury work?	4 ⊔ Nursi at	280	5 Reside	$\overline{}$	Other (Spector)	city) HOSPICIZ
LIVISION al or Attendir s after death. al Director: Af	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inju		ırm, stree			_	Location (St City or Town		l Number or Ru	ural Route Number,
e Hospita 124 hours e Funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of only one) Certifying Nurse Practioner: To the	kamination and/c	or investig	gation, in my opinior	n, death occu	irred at the	time, date an	d place,	and due to the	cause(s) and manner stated.
To th within To th	-	29b. Signature and title of certifier		9-1	29c. License	number		2		e signed (Mont	
TE.		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pr	int)	4WY	. 1	AL O		071	X) 2
Sta	ate		r's Signature	1	133 3	AUI	13 00	7	u	2 01	
Registi		JUN 9 1 2011	~ B.	pa	New York						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar 22302 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2ďľ1 OT 13:10 <u>Kevin Joseph Jackson</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 999 West Patrick Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day April 21 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours Year 1969 42 Yrs **Director** 579-82-7154 Usual Residence of Deceder should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Hillcrest Heights Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4013 24th Place 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify. **Black** Completed 3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Driver Automotive permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonard Robinson Joanne Elizabeth Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deana Lynn Jackson/Ex-Wife 116 Cherokee Street, Satsuma, FL 32189 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $\text{July}^{\text{Date}}$ cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service ouce, Keeney and Basford PA Funeral Home MO1473 106 E. Church Street, Frederick, MD 21701 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the diseas shock, or heart failure Approximate Interval Between Immediate Cause (Final Onset and Death anter Ph. sician/ coronary disease or condition Medical resulting in death) Examiner cardism 0) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live tail Color Pregnant at time of death Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No been signed by the a should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 2 1 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending work within 24 hours after death.

To the Funeral Director, Af
completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. only one) 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Mar 5

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / D	epartment of Health Certificate of Death			1 22303
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Sertificate of Death	2. Date of	Reg. N201	3. Time of Death
	Physicia		John Young Jones Jr.		Month June	_	Year 12:00a M
parties and	Medic		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		4c. County o	
	9		Kline Hospice House	Mt. Air	v		derick
Ī	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		er 24 Hrs. 8. Date of I		Birthplace (State or Foreign Country)
h	Director		352-20-5711 85	rs.	March	7, 1926	Illinois
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	· ·		10d. Inside City Limits
	faryla 3a-f s tified	Director	Maryland Frederick Frederi	ck			1 ☐ Yes 2 🛣 No
	or 28	Δİ	10e. Street and Number	10f. Zip Code		10g. Citizen of Wh	nat Country?
	s 23a	Funeral	6630 Jefferson Blvd.	21703		United	States
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic O. If Yes, specify Cuban, Mexica	origin? (Specify Yes or Nan, Puerto Rican, etc.)		- American Indian, White, etc.
36	after I", or xamii	d by	1 ☐ Never Married 2 🐹 Married 1 🐹 Yes 2 ☐ No	1 ☐ Yes 2 🖾 No Specifi		Specify:	
Maryland 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er, the Medical Examiner must be notified at	Completed	real or Dates. THEE	Decedent's Usual Occupation		16b. Kind of Bus	White
72	an "n Medi	mp	(Specify only highest grade completed)	Give kind of work done during mo ife. DO NOT use retired)	ost of working	16b. Killd of Bus	iness industry
2	withing giene giene that the		College (1-4 of 54)	School Teacher		Public	Schools
nd	be filed yeental Hygeked oth	o Be	17. Father's Name (First, Middle, Last)	18. Mot	ther's Name (First, Midd	le, Maiden Surname)	
₹	should be file and Mental I 7 is marked o raumatic eve	7	John Young Jones Sr.	Ion	na Needham		
Nar	shou h and 7 is n traum			Mailing Address (Street and Numb			
	pe 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			30 Jefferson Blv Disposition (Name of	vd. Frederi Date		and 21/03 Dity or Town, State
Baltimore,			200.71000 011				
를	permit. Page Department Important: If any injury or once.		4 Donation 5 Other (Specify) Mt. Zi.	on Lutheran Cem	etery'	Middleto	wn, Maryland
Ba	Dep:		John Olymen	Stauffer Fune 1621 Opossumt	ral Homes Hownes Hown Pike, I	rederick,	Maryland 21702
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause or each line.	t enter the mode of dying, such as	s cardiac or respiratory	arrest,	Approximate Interval Between
	Physician/	i	Immediate Cause (Final disease or condition	disease			Onset and Death
	Medical Examiner		resulting in death) ue to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	·			
	red nsit	Examiner	Cause (Disease or linjury				
	n and	Exa	that initiated events c. Due to (or as a consequence of	:			
09	certificate be executed anding physician and use as the burial-transit	dical	d				
-		Med	IF FEMALE:				
x 68	requires that the death certific been signed by the attending is should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 Ectopic pregnancy			of delivery
Box	that the death ned by the atte detached for	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)		_ Mont	th Day Year
o.	at the d by t letach	Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Par	rt I. 23e Di	tobacco use contrib	oute to the cause of death?
ď.	res th signe I be d	d by	Comman auter den	ound			B ☐ Probably 4 ☐ Unknown
ğ	requi been should	ete	he to the Colonia	il true	24a. W		ere autopsy findings available
Records,	e law e has ge 2 s	Completed	mayin como	19 79 m	au	topsy pr rformed? de	ior to completion of cause of eath?
<u> </u>	sician; The law certificate has b irector, page 2 s	e C	25. Was case referred to medical	26 Place of De	1 \(\triangle Ye\) eath (Check only one)	s 2 No 1	Yes 2 No
Vita	ysician: nis certific director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Othor	Nursing Home 5 🗆 Re	sidence 6 X Other	(Specify) Q 4 S A L Ca
o	g Ph er thi		27. Manner of Death 28a. Date of injury 28b. Tir	ne of 28c. Injury at		e how injury occurred	
Division of	endin eath. or: Aff he fur	Certificate:	2 Accident Investigation	ury work? M 1 □ Yes 2 [□ No		
NISI	r Att fter de irecte n by t	erti	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		(Street and Number own, State)	or Rural Route Number,
Ξ	To the Hospital or Attending Physician; The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be		One Cartificate 1 Property St. 1		d aleas 1 1: 1: 1:	aauaa(a)	an atatad
	Hos 24 hc Fun	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do (Check 2 Medical Examiner: On the basis of examination and/or explored) Certifying Nurse Prestigent: 15 the best of my knowledge.	investigation, in my opinion, death o	occurred at the time, dat	e and place, and due t	to the cause(s) and manner stated.
	To the within To the complex	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowle 29b. Signature and title of certifier	29c. License number		29d. Date signed	
			I Sed Halina man	\cap 22	101	0	23 7011
	15+1		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)	701	1	73/1000
	13		Llega Halverson un 1	475 tane	y ay	Tule	red hel
	Stat		31. Date filed (Month, Day, Year) 32. Bugistrar's Signature	1.41	(21702
	Registra	ar -	JUN 2 4 2011 Sum B.	garke			

Registrar

State

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Types Print)

ffice Road, Waldorf, MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Marie Gilchrist Jallings Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 505 High Acre Drive, Room 230 Westminster If Under 1 Year If Under 24 Hrs. 5 Social Security Number 248-09-4332 548-24-8875 7. Age (In vrs. last birthday) Funeral 1 M 2 F 94 Director 10a. State 10b. County 10c. City. Town or Location Director "natural", or items 23a or 28a-f s dical Examiner must be notified MD Carroll Westminster 10e. Street and Number 10f. Zip Code Funeral 505 High Acre Drive, Room 230 21157 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Accountant

8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Yea 9/9/1916 SC 10d. Inside City Limits 1 ☐ Yes 2 XNo

Black, White, etc

2011 2011

4c. County of Death

Carroll

22305

2:40 P M

10g, Citizen of What Country? USA 14. Race - American Indian,

2 Date of Death

Month 06

Specify: White 16b. Kind of Business Industry Atomic Energy Commission

Reg. No.

18. Mother's Name (First, Middle, Maiden Surname) Sara McCord

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

76 Marhill Ct., Westminster, MD 21158

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Inc 06/16/2011 Hampstead, MD 21074

22. Name and Address of Facility Pritts Funeral Home & Chapel $211\overline{57}$ 412 Washington Road, Westminster, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Coroner disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy
5 Other (specify)

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

23d. Date of delivery

24a. Was an autopsy 1 🗌 Yes 26 Place of Death (Check only one

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Year

25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DC	Other: 4 Nursing Ho	ome 5 Residence	6 ☐ Other (Specify)						
27. Manner of Death	28a, Date of injury	28b, Time of	Bc Injury at	28d Describe how init	in/ occurred						

(Month, Day, Year) work? injury 1 Natural 5 Pending Investigation

Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

28f. Location (Street and Number or Rural Route Number,

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deaut occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

D38915 30. Name and address of person who cor

ted cause of death (Item 23a) (Type, Print) stenes Aul westungtes 2115 REI 291

KX+A LIL 31. Date filed (Month, Day, Year)

State Registrar

event, th

Important: If iten any injury or other

Physician/

Medical

Examine

Physician/Medical

Completed by

Be

မ

Certificate:

Medical

Examiner

attending physician and for use as the burial-transit

this certificate has ral director, page 2

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

that the death certificate be executed

Box 68760

Division of Vital Records,

Baltimore,

Be

ည

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

1 Yes 2 No

IF FEMALE:

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licen

William Robert Gilchrist

Rae Gilchrist Testa/sister

1 Burial 2 X Cremation 3 Removal from State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22306 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:00m Dorothy Leona Jenkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 - M 2 - F Hours 218-30-7541 7/47 1935° Maryland **Director** 76 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Numbe ms 23a or must be r ō 10f. Zip Code 10g. Citizen of What Country? Funeral 518 West Church Street 21740 U.S.A. items ; within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married ò þ Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 'natural", 3 Widowed 4 Divorced Specify. Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked of မ Shantz George Helen. Marie Yeager injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard E. Jenkins / Spouse 518 West Church Street, Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 7/8/2011 Hagerstown, Maryland of Funeral Ser 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LIVER disease or condition Medical resulting in death) Examiner UNKNOWN SMILLER METATTATTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Box 68760 the attending | for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown the signed by t Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YPE 2 DIAGETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed CONGOSTIVE HEART FOILURE Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy OBSTRUCTUS PULMONORS death? 2 🗌 No 1 Yes Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes ᅆ 1 Inpatient 2 □ ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ne Funeral Director; At poleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

To the F
complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar

State

1 3 2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month DAISY MAE **JOHNSON** June 27, 2011 8:30 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death McCready Memorial Hospital Crisfield Somerset 5. Social Security Number If Under 1 Year Age (In yrs. last birthday Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 113℃M 2□F 217-36-1554 Director 01/16/1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at Director Maryland 1 ☐ Yes 2 TNo Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3399 South Somerset Avenue 21817 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death "natural", or items dical Examiner m 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Custodian Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Jones Estelle M. Lee 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell George Johnson, Jr. 3399 South Somerset Ave. - Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State Crematory of Delmarva 06/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, Robert H. Bradshaw, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melanoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause to be seen and conting Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ been sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an has performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral o 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural within 24 hours after death.

To the Funeral Director: 2 Accident 1 TYes 2 TNo filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of partifier 29d. Date signed (Month, Day, Year) 06, 27, 2011 50 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	Registrar	25tato of Marylan	nd / Depart Certifi	797139f21493 icate of Dea	th and Mental H th	ygiene Reg. N2011	22308
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nd	faryland Ba-f sho tified at	Funeral Director	10a. State 10b. County MD Cecil		ty, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 📈 No
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st Raymend	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates. 1960-	_		c Origin? (Specify Yes or N xican, Puerto Rican, etc.)		erican Indian, e, etc.
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Kr	Page 1 ment of I tant: If its ury or of		1 W Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State Ang	cemetery, cremato 3 eL Hill	ry or other place) Cemetery		Havre de Gr	iace, MD
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Knownto 760	s be e ysicia: e buri	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a consequence) Due to (or as a consequence)					
Jame K O. Box 687	requires that the death certificate been signed by the attending phi should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🔲 Ec	topic pregnancy her (specify)		23d. Date of de Month	elivery Day Year
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S 1	nding Ph ath. r: After th e funeral	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? VI 1 ☐ Yes		e how injury occurred	
2.5 Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	l Certif	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street,	factory, office	28f. Location City or 7	n (Street and Number or Ru own, State)	iral Route Number,
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	Voithii Comp		29b. Signature and title of certifier	1100 11		29c. License numl	ber	29d. Date signed (Mont	
	6		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)	740	1005	<u> </u>	o foint masigos
	Stat Registra	6	31. Date filed (Month, Day, Year) JUL 1 3 20	32 Registrar's Signa	. Sax	Inungland	Health Care	system, ten	1 TOME MONEY

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 22. 2011 Debra Baum Kushner 11:25p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X F Months Hours 10/07/1949 Washington, DC Director 219-48-0027 61 Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 U.S.A. 14740 Locustwood Lane death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed Caucasian Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) Health Care Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Marilun Kaminker Stanley Baum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth a Important: If item 27 is any injury or other trau 14740 Locustwood Ln., Silver Spring, MD 20905 Elliot Kushner - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 06/26/2011 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service License M1564 atri 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Malignant Melanoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Pregnant at time of death 9 Unknown 9 Unknown as been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe After this certificate 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? s after death. 1 Yes 2 No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

DHMH 17 Rev 7/2009

Debrah Miller, CRNP,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R143201

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State o	of Maryla	nd / Dep <i>Ce</i>	artmer ertificat	nt of H e of D	lealth Death	and N	/lental Hy	/gien Reg. N	20		223	10
Physicia	m/	1. Decedent's Name (First, N	iddle, La	ast)							2. Date of D)av	Year	3. Time of D)eath
Medic	cal	Edward John	-								06		5 5	2011	2:50	РМ
Examin	er	4a. Facility Name (if not instit	_		nber)			Town, or Emins	Location	of Death		4	c. County			
Funeral		5. Social Security Number	6.	Sex	7. Age (In yrs	. last birthday)	If Unde	r 1 Year	If Unde	r 24 Hrs.	8. Date of Bi				lace (State or I	Foreign
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner			d												
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23^{ay} Jumeth 201°1 09:52 Ам Marv Helen Kalandros Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 797 Eastern Point Road Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔏 F 0393171935 New Tersey Director 76 580-66-7182 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Annapolis 6 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 797 Eastern Point Road 21401 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 — Yes 2 — No If Yes, Give 14. Race - American Indian. Black. White, etc. "natural", or 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Education Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Rose Pagan lHerman L. Lettich 19a. Informant's Name/Relationship (Type, Print)
Kosmas Karavellas/Personal Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 2747 Riva Road, Annapolis, Maryland 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Demetrios Cem. 06/27/2011 Annapolis, Maryland 21. Signature of Jungral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ habdomyosarana disease or condition HERS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No Unknown 9 Unknown been signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown Nο 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 perforr certificate 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

ical Parcian

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 2 7 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year 2011 Marsha Keshani 25 Ann June 8:58 PM M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12104 Bentridge Place Potomac Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🛛 F Months Hours Min Month, Day July 15 551-74-2083 61 1949 Michigan **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Potomac 1 🗌 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12104 Bentridge Place 20854 United States . Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Completed 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Owner/Operator Ice Cream Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Skrobecky Nellie Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mahmood Keshani (Spouse) 12104 Bentridge Place, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 28, permit. Page 1 and Department of I cemetery, crematory or other place;
All Souls Cemetery Important: If 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 2011 Germantown, Maryland Signature of Funeral Service Ligensee 22. Name and Address of Facility DeVol Funeral Home M00689 10 East Deer Park Drive Gaithersburg, MD 20877 23a Part I. In ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, by heart failure. List only one cause on each line.

Imme listed ause (Final disease or condition Liver Failure Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Colorectal Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Tanel Cause (Disease or iinjury that initiated events resulting in death) Last Cirrhosis that the death certificate be executed Due to (or as a consequence of) burial-t physician the burial Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the atte Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pade performe 1 Yes 2 No 2 🔀 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury

Box 68760 P.0. Records, After this certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical Division of Vital funeral director. completed filled in by

5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D35033

June 27, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Jon Pishvaian, MD, Ph.D. 3800 Reservior Rd., NW Washington, DC 20007

State Registrar

10

Medical

31. Date filed (Month, Day, Year) Registrar's Sig JUN 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 21 201 Year Ronald J. Lowing 1300 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery 01nev If Under 24 Hrs. 8. Date of Birth Month, Day, 10 Dec. 17, . Social Security Number If Under 1 Year Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Director 220-70-7616 Michigan 55 ็I 955 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State aţ 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20882 9709 Stanton Hall Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian ori Black, White, etc. à 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Self Employed Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jack Lowing Janet Postema Lowing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen S. Lowing, Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 9709 Stanton Hall Court, Gaithersburg, MD 20882 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
All Souls
Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 25,2011 Germantown, Maryland 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 21. Signature of Fund rel Service 23a. Part 1 Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician acterem disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (o cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit topenia the Hospital or Attending Physician: The law requires that the death certificate be executed Pan Cytope
Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown n signed by ti Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rladder 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 ☑ No Corc 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, |@ 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my online, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NO068026 21/2011 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 PADMAJA BANDI PHILIP PRINCE 8101 OLNE 32. Registrar's Signature State

Registrar

JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22314 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Radler Lord Month Year Audrey 0500 2011 Une Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death TALBOT Easton Memorial Hospital at EASTON Age (In yrs. last birthday)
75 Yrs. Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 163-30-0411 1 □ M **X**IX F Hours Octont 2 ay, Pennsylvania Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Dorchester Cambridge 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Bayview Avenue 21613 US 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Maryland 21215-0036 þ 1 Never Married 2XXMarried 1 ☐ Yes 2 TXNo If Yes, Give XX Year or Dates. 1 ☐ Yes 2XXNo Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell Radler Nellie Hea1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Lord Husband 102 Bayview Avenue Cambridge, Maryland 21613 Baltimore, 20a. Method of Disposition
1 □ Burial 2 TCremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Crematory of Delmarva 6/26/2011 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 Funeral Service Licensee 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year sate has been signed by the page 2 should be detached 9 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Cancer 24a. Was an autopsy perform death? this certificate Yes in 24 hours after death.

the Funeral Director, After this certifical projected filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury examiner? 2 Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title 29c. License numbe

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mom

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22315 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 21, D2011 Year 6:55 William Edward Lord Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death c. County of Death Prince George's 1117 Wentworth Drive Oxon Hill Social Security Number If Under 1 Year I If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1**X** X M 2 □ F Days Hours **61723719**37 494-40-1798 Missouri Director 74 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Oxon Hill 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 1117 Wentworth Drive 20744 USA 12. Was Decedent Ever in U.S.
Armed Forces?

**XX Yes 2 \sum_{No} 1955If Yes, Give 1987 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Year or Dates. 1987 1 Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Military U.S. Navy vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Glenn Edward Lord Alice Kilgore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minako Lord - Wife 1117 Wentworth Dr., Oxon Hill, Md 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 06/29/2011 Kalas Crematory 4 Donation 5 Other (Specify) Edgewater, Maryland 21. Signatur of uneral Sepice Licenses 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. ales 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ending Physician; The law requires that the death certificate be executed ysician and e burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical anding p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown the a signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 1 💆 Natural 28a. Date of injury (Month, Day, Year) icate: 28h Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No Accident Number or Rural Route Number

Box 68760 P.O. Records, of Vital

Divis	tal or Att rs after d al Direct ed in by	al Cert	4 Homicide determined	 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	the Hospitathin 24 hours the Funeral mpleted filler	Medical	(Check 2 Medical Examiner	an: To the best of my knowledge, death occured at the time, date and place, on the basis of examination and/or investigation, in my opinion, death occurred tractioner: To the best of my knowledge, death occurred at the time, date and p	d at the time, date and place, and due to the cause(s) and manner stated
	To the within 2 To the Comple		29b. Sig nature and title of pertifier	29c. License number D7010Z	29d. Date signed (Month, Day, Year) 6-22-2011
Ū	1 941		DR I VAIR LAMA	pleted cause of death (Item 23a) (Type, Print), M. D. 9200 Bosin Ct., See 260	Largo, MD 20744
PIL	Stat Registra	ar	31. Date filed (Month, Day, Year) JUN 2 4 201	32. Registrar's Signature	1 . ,
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			For State Registrar	State of Maryla		artment of tificate of			giene Reg. N. 2011	22316					
	Physicia Medi			igene Barry Le	iderman			2. Date of Dea Month June	24, 2011 Year	3. Time of Death					
	Examir	ner	4a. Facility Name (if not institution, giv Suburban Ho				or Location of Deat Bethesda	h	4c. County of Dea	ath tgomery					
	Funeral Director	Г	Social Security Number 6. 5	Sex 7. Age (In yrs.	last birthday) § Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day April 0	h 9. B	irthplace (State or Foreign					
			Usual Residence of Decedent					April 0	17,1943 Wa	shington, DC					
	//arylan/ 8a-f sh tified a	ecto	,	tgomery 100.C	ity, Town or Lo		lorth Bet	hesda		10d. Inside City Limits 1 ☐ Yes 2 ☑ No					
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	*					
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nore	m 0 <u>u</u> <u>u</u>		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☒ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State		atory or other pla		Date 7.6 / 2.0 1.1	20c. Location - City of	r Town, State I ch, Virgini a					
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licen		22.	Name and Addre	ess of Facility H	ines-Rina	aldi Funera	ul Home, Inc.					
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	Ph _{sician/}		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)												
Same?	Medical Examiner		resulting in death)	Due to (or as a consect by Heart Fact											
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n of \	ding Phy h. After this funeral d	ate: To	27. Manner of Death 1	1 Name of Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time of injury	28c. Injur	y at ⟨?		ence 6 Other (Spe	cify)					
Division of Vital Records, P.O.	or Atten after deat Director: in by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	De 280 Place of Injury At h	ome, farm, stre		Yes 2 □ No	28f. Location (Si City or Town	treet and Number or Ru n, State)	ural Route Number,					
	ospital hours a uneral E	Medical (29a. Certifier 1 🗶 Certifying Phy (Check 2 Medical Exam	vsician: To the best of my know	vledge, death o	ocured at the time	e, date and place, a	nd due to the cau	use(s) and manner as st	ated.					
	o the H ithin 24 o the Fi omplete	Me	only one) 3 Certifying Nur 29b. Signature and title of certifier	niner: On the basis of examinations of examinations of macrimer: To the best of macrimers of the best of macrimers.	ny knowledge, d	eath occurred at the	e time, date and pla	ice, and due to the	nd place, and due to the cause(s) and manner as 29d. Date signed (Mont	s stated.					
	Zo		- \	tatuis			D59980	'		4, 2011					
-			30. Name and address of person who sandra M. Delista				own Road	: Bethes	da, MD 20	814					
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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrate ND#29aperCRNP; 6/29/11; BWW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year ORIA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOPKINS CAR (ENI MO MO Social Security Numbe 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth _ (Month, Day, **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Min. 1962, ^{Year)} Hours **Director** 49 Yrs Florida 230-06-9589 January Usual Residence of Decedent show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Montgomery 1 Yes 2 X No Damascus 10e, Street and Number ò 10f. Zip Code ral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 9813 Bethesda Church Road #204 20872 United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Caucasian nan "natural", Medical Exar 1 Yes 2 No Specify: 3 Widowed 4 N Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental I is marked or ပ္ Michael Kropp Sharon Kelley other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Bethany Martinez, Daughter 18411 Lost Knife Circle #203, Montgomery Village, MD 20a. Method of Disposition
1 ☐ Burial 2 🏅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 06/29/2011 Brentwood, Maryland 21. Signatur of Funeral Service Licensee MO1102 Simple Tribute 22. Name and Address of Facility 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner months Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury anc that initiated events resulting in death) Last Due to (or as a consequence of) urial tending physician or use as the ouria Physician/Medical Division of Vital Records. P.O. Bo. 68769. To the Hospital or Attending Physician: The law requires that the decrepting at the pour after death.

To the Funeral Director. After this certificate has been signed by the trending physic completed filled in by the funeral director, page 2 should be detached or use as the 2 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Characteristic properties of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

JUN 28

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RAYVIEW

State of Maryland / Department of Health and Mental Hygien

Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** Year Sterling Eugene Martin 1:17 P 2011 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll County Long View Nursing Home Manchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ★M 2 □ F 81 Director 216-22-8708 May 27, 1930 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Carroll County Director Maryland Hampstead 1 ☐ Yes 2 No d other than "natural", or items 23a or 28a-f s event, the "dedical Examinar must be not the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 2 rry or other traumatic event, the Medical Examiner must be an 1618 Fairmount Road 21074 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 195
If Yes, Give 105 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1951 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u></u> Specify white 3 Widowed 4 Divorced 1952 Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) truckdriver manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Martin Margaret Keeney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lavina Mae Martin / wife 1618 Fairmount Road Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other n 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial permit. Page Department of Important: If any Injury or once. June 18, 2011 Finksburg, Maryland **Gardéns** 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 Iwwn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheime **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any local glocal g Due to for as a consequency offirequires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) signed by the a Division of Vital Records, P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Sec autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending rinys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) canovaiga, 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. PANSURIYA 3 +9 North Column DR. Westminster 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ju<u>ne</u> 2011 Sor Miech 1744 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day,
April 0. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🏿 F Country) Cambodia Hours 220-06-7368 83 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Rockville 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13403 Keating Street 20853 Cambodia 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 Tes 2 X No Specify. 3 X Widowed 4 Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Miech (Unobtainable) Sak (Unobtainable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thay Min - Daughter 13403 Keating Street, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🕱 Cremation 3 ☐ Removal from Ştate 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 06/27/2011 Brentwood, Maryland of Fun ral prvice Lic 22. Name and Address of Facility Hines-Rinaldi Funeral Home 1021/11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): Large Bowel Obstructing Mass Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery Month Unknown ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical **Examiner**

and

attending physician a for use as the burial-

signed by the a

requires that the death certificate be executed

Physician; The law certificate has page

Hospital or Attending

After this

within 24 hours after death.

To the Funeral Director: Af

completed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Examiner

Funeral

Director

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Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner Tremsit Physician/Medical Completed by Be ည Certificate:

If any, leading to immediate cause. Enter Underlying Cause (Disease or linijury that initiated events resulting in death) Last
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
Part II. Other significant cond

25. Was case refer examiner?

1 Tyes

27. Manner of Death

1 X Natural

Accident

4 Homicide

29a. Certifier

Suicide

1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

28f. Location (Street and Number or Rural Route Number,

			24a. Was an autopsy performed
red to medical		26. Place of Death (Check on	ly one)
	Tile-mitels		

1 🕱 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, 2 X No 28a. Date of injury 28b. Time of (Month, Day, Year) 5 Pending Investigation 6 Could not be

28c. Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town. State 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

(Check only one) 3 ☐ Medical Examiner ; On the basis of examination and/or investigation only one) 3 ☐ Certifying Nurse Practioner : To the best of my knowledge, death of	n, in my opinion, death occurred at the time, date occurred at the time, date and place, and due to the control of the time.	and place, and due to the cause(s) and manner state
h O'read and a later of the second and the second a		29d. Date signed (Month, Day, Year)

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determined

D0068681

June 23, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charu Maheshwary, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day,

State Registrar JUN 2 7 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se Type or F							egible.		
		For State Registrar	State of	Marylar		artment of tificate of		Mental Hy	rgiene Reg. N 2 ()	22321	
Physicia		Decedent's Name (First, Middle		hos				2. Date of De Month	eath Day	Year	3. Time of Death	
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Funeral		Southern Mary 5. Social Security Number	CILIEO.									
Director		579 09 7045 Usual Residence of Decedent	6. Sex 1 M 2 D F	92	Yrs.				1919			
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nit. Page 1 a artment of H ortant; If ite injury or otf		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Software L		tate (cemetery, crem t Lincol	natory or other pla n Cemeter	June	30, 2011	Brentwo	ood, Mar	ryland	
регт Depa Impo any i	-	23a. Part 1. Enter the disease,	complications that cau	used the deat	3	Ferry Ro	oad, Clinto	on, MD 2073	35			
Physician/ Medical Examiner	Examiner	shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	a. Due to (or	as a conseq	5 clerts	Car	Emos Lovara	rehgs ilan j	Pise	6.10		
£ = £		that initiated events resulting in death) Last	d.	as a conseq	uence of):							
he death cert y the attendir iched for use		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Bir	th 2 Teta	al death 3 🗌		су					
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To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	al Certificate:						et, factory, office 28f. Location (Stree City or Town, S			eet and Number or Rural Route Number, State)		
the Hospi nin 24 hou the Funer upleted fill	Med	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best kaminer: On the basis Nurse Practioner: To	of examination	n and/or investi	gation, in my opini	on, death occurred	at the time, date a	and place, and	due to the ca	use(s) and manner stated.	
No Portion		29b, Signature and title of certifier		1.1		29c. Licens	765		29d. Date sig	-22-	2015	
85		30. Name and address of person w	ho completed cause of	of death (Item	23a) (Type, Pr	rint)	ingsca	116	roi for	-UA	rhta	
State Registra	,	31. Date filed (Month, Day, Year)	9 2011 32. Reg	strar's Signa	ture B. A	barked	· 1 50		· / ' '	MO	syta- 2074	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ State		artment of Health and tificate of Death	wiorital Try	Reg. NO. 0	11 22322
		Registrar 1. Decedent's Name (First, Middle, Last)	Oei	uncate or beating	2. Date of De		3. Time of Death
Physic		Norman Raymond Myers			Month June	Day	Year 2011 2:05 P M
Med Exam		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Deatl		4c. County	
		16575 Prince Frederick Rd.		Hughesville		- 1	rles
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt	h Vearl	Birthplace (State or Foreign Country)
Directo		230-09-1149	Yrs.	World Bayo Hours Will.	(Month, Da 03/03/1	922 _	Washington D.C.
nd how at	5	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loc	cation			10d. Inside City Limits
laryla 3a-f s	Director	Marvland Charles Hu	ughesvi	1110			1 ☐ Yes 3x 1x No
or 28	قَ	Maryland Charles Ht 10e. Street and Number	ugnesvi	10f. Zip Code		10g. Citizen of	What Country?
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death item	Fu	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puert	ecify Yes or No-		e - American Indian,
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than "matural", or items 25a or 26a-f sho the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 X Yes 2 No		I ☐ Yes 2 🛛 No Specify:	, , , , , , , , , , , , , , , , , , , ,		ck, White, etc. : White
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land 21215-0036 be filed within 72 hours after death with the Maryland lental Hygiene. rked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle, Last)			ne (First, Middle,		e)
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ore, Marylar t and 2 should be to of Health and Ments fitem 27 is marked	10	19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street and Number or Ru			
		Brenda Mae Lynch/Daughter 20a. Method of Disposition		Prince Frederic	K Kd., I		- City or Town, State
Page 1 Page 1 ant: If it		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	natory`or other place)			
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othel		21. Signature of Funeral Service Licensée		em. Gardens 07/ . Name and Address of FacilityBri			
Balti permit. Departr Importa any inju	1	Hartin Columnia MI MOOR		0195 Three Notch			-
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x 68/	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Feta	ancv				
Box death o		in the past 12 months?	al death 3	Ectopic pregnancy		23d. Da	ate of delivery
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To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Certificate: To Be Completed	Part II. Other significant conditions contributing to death but not res 25. Was case referred to medical examiner? 1	ER/Outpatien 28b. Time of injury Dime, farm, strey Iedge, death on and/or investing knowledge, death 1234 (Type, Pr. 234)	26. Place of Death (Che 26. Place of Death (Che 27. DOA 28. Injury at work? M 1 Yes 2 No 28. No 28. Injury at work? M 1 Yes 2 No 29. No 29. No 29. Occurred at the time, date and place, a ligation, in my opinion, death occurred	24a. Was autop performed to the case at the time, date a ace, and due to the	bbacco use cont Yes 2 No an 24b. In a 24b. In	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No er (Specify) ed er or Rural Route Number, er as stated. e to the cause(s) and manner stated. anner as stated.
NB3	Medical Certificate: To Be Completed	Part II. Other significant conditions contributing to death but not res 25. Was case referred to medical examiner? 1 Yes 2 No	ER/Outpatien 28b. Time of injury Dime, farm, strey Iedge, death on and/or investing knowledge, death 1234 (Type, Pr. 234)	26. Place of Death (Che 26. Place of Death (Che 27. DOA Other: 4 Nursing H 28c. Injury at work? 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28c. Injury at work? 28c. In	24a. Was autop performed to the case at the time, date a ace, and due to the	bbacco use cont Yes 2 No an 24b. In a 24b. In	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No er (Specify) ed er or Rural Route Number, er as stated. e to the cause(s) and manner stated. anner as stated.

13

Physician/

Medical

Examiner

Funeral Director

Director

Be Completed by Funeral

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Medical Certificate: To Be Completed by Physician/Medical Examiner

For State Registrar	State of Ma		ertificate of		-	Reg. No	201	1 22323
Decedent's Name (First, Middle, La	ast)		<u> </u>		2. Date of De	ath		3. Time of Death
Carol McGoneg			1		June 2	2, 2	011 Yes	7:05 AM
a. Facility Name (if not institution, give	· ·			or Location of Dea	ith	40	County of D	eath Arundel
1101 Opaca Cour		'In yrs. last birthday)	_ 1	nsville	s. 8. Date of Bir	th		Birthplace (State or Foreign
155-38-8169	1 □ M 2 K F	64 Yrs.	Months Days	Hours Min			Ne	Country Jersey
Usual Residence of Decedent Oa. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
Maryland Anne A		roo. only, rown or E	ocation	Crownsv	ille			1 Yes 2X N
0e. Street and Number	- 1		10f. Zip Code			10g. C	itizen of What	Country?
1101 Opaca Cour	rt			21032				USA
1. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of If Yes, specify Cu	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Al Black, W	merican Indian,
1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	0	1 Yes 2 1				Specify: W	
15. Decedent's		16a. Dece	edent's Usual Occi	pation		16b k	Kind of Busine	es Industry
(Specify only highest g Elementary/Seconday (0-12)	grade completed) College (1-4 or 5+)	life	e kind of work done DO NOT use retired	during most of w	orking			, and made y
	5+	Sof	tware Eng				rivate	<u> </u>
7. Father's Name (First, Middle, Last) Harold Francis		Conecal			_{ame (First, Middle,} Rose Guo		Surname)	
9a. Informant's Name/Relationship (ling Address (Stree	1			r Town State	Zin Code)
Edmund Munger -			1 Opaca (
Da. Method of Disposition	7.0	20b. Place of Disp	osition (Name of ematory or other pl	unk	Date	20c. L	ocation - City	or Town, State
4 Donation 5 Other (Spec		Arlington				Ar1	ington	ı, VA
Signature of Funeral Service Licer	isee							eral Home
Juglin 16	dever						napoli	s, MD 21401
23a. Part 1. Enter the disease, or cor shock, or heart failure. List only mmediate Cause (Final	one cause on each line.	1		ng, such as cardia	ic or respiratory ar	rest,		Approximate Interval Between Onset and Death
lisease or condition esulting in death)	a. Vocure	トラリドゥ consequence of):	MIB					4 mos
				NONOM	E			1996
sequentially list conditions, any, leading to immediate		b. MYITO THE SYNDROME Due to (or as a consequence of):						
cause. Enter Underlying Cause (Disease or iinjury hat initiated events	C							
resulting in death) Last Due to (or as a consequence of								
	d							
FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of	dolivon
	1 Live Birth 2 4 Pregnant at ti		☐ Ectopic pregnat ☐ Other (specify)	ncy			Month	Day Year
in the past 12 months?	Q 1 Inkanius							
in the past 12 months? 1 ☐ Yes 2/KLNo 9 ☐ Unknown	9 🗌 Unknown			iven in Part I	23e Did to			to the cause of death?
in the past 12 months? 1 ☐ Yes 2/KLNo 9 ☐ Unknown		not resulting in the	underlying cause o	ivon in raici.				Probably 4 Unknown
in the past 12 months? 1 ☐ Yes 2/KLNo 9 ☐ Unknown		not resulting in the	underlying cause (, voi i i i aici.		Yes 2		
in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		not resulting in the	underlying cause o		1 🗆 24a. Was autoj	an osy	24b. Were	autopsy findings available to completion of cause of
in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown art II. Other significant conditions		not resulting in the			1	an	24b. Were prior to	autopsy findings available to completion of cause of
in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions	contributing to death but		26.	Place of Death (Ch	24a. Was autoperfc 1 Yes	an osy ormed? 2,23.N	24b. Were prior 1 death	autopsy findings available to completion of cause of 1? Yes 2 No
in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death	contributing to death but Hospital: 1 Inpatien 28a. Date of injury	t 2 ☐ ER/Outpatie	26. I	Place of Death (Ch ner: 4 □ Nursing ry at	1	an osy ormed? 2₽ X N	24b. Were prior 1 death 1 🗆 \	autopsy findings available to completion of cause of 1? Yes 2 No
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in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions 5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending	Hospital: 28a. Date of injury (Month, Day,)	t 2 ER/Outpatie /ear/ 28b. Time of injury - At home, farm, st	26. Injury 3 DOA Ot 28c. Injury Wo 1 E	Place of Death <i>(Ch</i> ner: 4 Nursing ny at k?	24a. Was autoj perfic 1 Yes eck only one) Home 5/A Resid 28d. Describe h	an osy ormed? 222 N	24b. Were prior to death of the control of the cont	autopsy findings available to completion of cause of 1? Yes 2 No

29c. License number

MEDIGAL

2003

10811

29d. Date signed (Month, Day, Year)

ANNAULIS mo

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21701

2011

State Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

37. Registrar's Signature

WATKING

29b. Signature and title of certifier

31. Date filed (Month, Day Year)
JUN 2 3 2011

STANUET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 26^{Day} 2011 Samue1 Shepard Dennis Marsh 9:52 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery 8048 Cindy Lane Bethesda 6. Sex 1 ★ M 2 □ F . Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthdav) Country D.C. Days oct. 29, Year) 926 577-44-5835 84 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Ves 2 K No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a Funeral 8048 Cindy Lane 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc ^{2 □}No ve WWII era þ 1 Never Married 2 X Married 1 XYes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ੌ No Specify: Specify: White 3 Nidowed 4 Divorced Completed Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Estate Planning Attorney is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold N. Marsh Dorothy Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Judy J. Marsh/Wife 8048 Cindy Lane, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State June 2011 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee, Francing Address Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Md 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Renal Disease Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-trun Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) hed by the atter in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 🗌 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?

Yes 2 No page death? certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A:
completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License numbe D20148 29d. Date signed (Month, Day, Year, June 27, 2011

State Registrar

DHMH 17 Rev 7/2009

911 Russell Avenue, Gaithersburg, MD 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sigeature

Steven Dolinsky, MD

JUN 28 2011

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:45,0 M **Physician** JUNE MARTIN 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Vantage House Columbia Howard If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 4/3/1920 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖸 F 91 578-05-9025 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sho notified a Director 1 Tyles 2 □ No Columbia Md. Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 5400 Vantage Point Rd. Apt. 814 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) the Property Management Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd 2 should be fillth and Mental H 27 is marked ott r traumatic ever Be t and 2 should be Health and Ments Mollie Lubitch Sokolow Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6125 Loventree Rd. Columbia, Md. 21044 Bruce P. Martin/ Son item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important; If any Injury or = 5 Falls Church, Va. King David Memorial Gardens 6/26/11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Danzansky Goldberg Memorial Gardens Edward Sagel M00910 <u>1170 Rockville Pike Rockville, Md. 20852</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ENDOMETRIAL **Physician** /Medical Due to (or as a consequence of): Examiner DEBILI Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed' funeral director, 25. Was case referred to medical examiner? 1 antige 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 18 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE MUZIZOI

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 28 2011

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Pl, SLIE 32. Registrar's Signature

			State of Maryland / Dep			2111	22326			
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death		g. No. UII				
	Physicia Medic		REBECCA JEAN MCCRAW		2. Date of Death 06/23/20	11 ^{ay} Year	3. Time of Death 2:10 A M			
***	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	th			
· may see and			Montgomery Hospice Casey House	Rockville		Montgome				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 03/10/19	ear) 9. Bir Co VA	thplace (State or Foreign untry)			
	d d		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	Continu			10d. Inside City Limits			
	arylan a-fsh fied a	Director	MD Prince George's Mt. Rain	-			1 Y Yes 2 □ No			
	or 28.	Dir	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	21			
	23a	eral	4301 Russell Avenue, #5	20712		USA				
	tems er mu	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	rican Indian,			
36	e filed within 72 hours after death with the Maryland trail Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Hican, etc.)	Black, White				
0	nours latura ical E	Completed	roar or Dates.	edent's Usual Occupation	1 1	Specify: Bla				
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21	iled within 72 Il Hygiene. I other than '	ပိ		rance Model		Cosmetic				
Maryland 21215-0036	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Charles Hill		ne (First, Middle, Ma	iden Surname)				
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Ma	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.			ing Address (Street and Number or Russell Avenue,		-				
re,	f Hearly		20a. Method of Disposition 20b. Place of Disp	osition (Name of		Oc. Location - City or				
Baltimore,	Page Tent o		The burnar 222 Oremation of Tremoval normatale	matory or other place) remation Sv 06/2		Hanover, M				
alti	permit. Pag Departmen Important: any injury once,					uneral Hon				
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			23a. Part 1. Enter the disease, or completations that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between			
	nysician/		Immediate Cause (Final disease or condition Pancreatic Cance	r			Onset and Death			
	Medical Examiner		resulting in death) Due to (or as a consequence of):							
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	ite be exe hysician a he burial-i	al E	resulting in death) Last Due to (or as a consequence of):							
760	cate b physic the b	edical	d							
687	eath certifica attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	liven			
Вох	e atter	Physician/Me	in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year			
O.	the d by the tacher	Phys	9 ☐ Unknown							
, P.O.	iires that the dea i signed by the a id be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to				
rds	v require been si should I	etec					robably 4 🕅 Unknown			
eco	e law i has b ge 2 s	Completed			24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of			
Ĕ	Physician; The law this certificate has al director, page 2 :		25. Was case referred to medical	26. Place of Death (Chec	1 \(\text{Yes} 2 \)		2 🗆 No			
Vita	ysicia s cert directu	To Be	examiner? 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	_ Other:		ce 6 🛛 Other (Spec	Hospice			
of	ding Phy th. After thi funeral		27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how		W HOSPICE			
on	• Attendir er death. ector: Af by the fui	ifica	1 ☒ Natural 5 ☐ Pending (Montin, Day, Year) Injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 No						
Division of Vital Records,	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-fansit	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,			
Ω	Hospital 24 hours Funeral I eted filled	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, a	nd due to the cause	(s) and manner as sta	ited.			
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred a	at the time, date and p	place, and due to the o	cause(s) and manner stated.			
	To the I within 2 To the I complete		29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	ı, Day, Year)			
D	6		* axiolah Mular CRN			6/23/1	1			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Deborah Miller, CRNP 6001 Muncaste	_{Print)} r Mill Road, Rocky	ville, MD	20855				
	Stat	е	31. Date filed (Month, Day, Year) JUN 2 8 2011 32. Registrar's Signature	20						
	Registra	ir	JUNIO ZUII CENON B. 1900							

	-	For State Registrar				of Health and	d Mental Hyg	3	22327
Physicia	n/	1. Decedent's Name (First, Mia					2. Date of Dea	th	3. Time of Death
Medic	al	Minnie Belle				· · · · · · · · · · · · · · · · · · ·		6, Day 2011 Year	11:47 рм
Examin	er	4a. Facility Name (if not instituti Bedford Court				wn, or Location of De ver Spring		4c. County of Dea	
Funeral		5. Social Security Number	6. Sex 7. A	age (In yrs. last birth	day) If Under 1	Year If Under 24 H	rs. 8. Date of Birth	9. Bir	thplace (State or Foreign
Director		147-22-8802 Usual Residence of Decedent	1 ☐ M 2 ☐ XF	104	rs. Months D	ays Hours Mi	March 23	0 ^{year)} 1907 Co	ountryMS
Aaryland 8a-f show tified at	Funeral Director	10a. State 10b. Cour	gomery	10c. City, Town	orLocation ver Sprin	g			10d. Inside City Limits
a or 2 be no		10e. Street and Number			10f. Zip Co	ode		10g. Citizen of What Co	ountry?
ns 23 must	ner	3700 Interna	tional Drive	, #336	20	906		USA	
rs after dea ral", or iter Examiner	by	11. Marital Status1 Never Married 2 Never Married 3 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 3 N	If Vee Cive	?		of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
ithin 72 hou ene. • than "natu he Medi al	Completed		dent's Education ghest grade completed) College (1-4 or	- 5+)	Decedent's Usual O (Give kind of work di life. DO NOT use ret Home Supe:	one during most of w ired)	-	16b. Kind of Business	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ou h	17. Father's Name (First, Middle Frank Carlos	e, Last)		iome bape.		lame (First, Middle, M e Lee Doo		
ind 2 shouk leatth and N m 27 is me her trauma		19a. Informant's Name/Relation Patricia A. K		utor 19b.	Mailing Address (St.) 707 Amhe	reet and Number or F rst Avenue	Rural Route Number, e, Silver	City or Town, State, Zi, Spring, MD	o Code) 20902
t. Page 1 a tment of H tant: If ite ijury or oth		20a. Method of Disposition 1 ☐ Burial 21 Crematic 4 ☐ Donation 5 ☐ Other	on 3 Removal from Stat	e cemetery	Disposition (Name of crematory or other olitan Cre	ematory J	Date 1 2 2 2 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1	20c. Location - City or Alexandria	, VA
permit Depar Impor any in		21. Signature of Funeral Service	e Licensee		22. Name and A Francis 500 Univ	ddress of Facility J. Collin ersity BLy	s Funeral	Home Inc.	g, MD 20901
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Medical Examiner		disease or condition resulting in death)	Due to (or as	to Thriv):				months
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The hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial traces.		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal death at time of death	3 ☐ Ectopic preg 5 ☐ Other (specif	nancy y)		23d. Date of de Month	livery Day Year
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ne nospii iin 24 hour he Funera	Medical	(OHECK Z LINEUICA)	ng Physician: To the best of Examiner: On the basis of the Jurse Practioner to be	examination and/or	rivestidation, in my o	ibinion, death occurred	at the time date and	I place and due to the r	college(s) and manner stated
With Co.		29b. Signature and title of certifi		10	1 29c. Lie	3845	7 2	9d. Date signed (Month	
		30. Name and address of person Nakul Goyal, M	n who completed cause of a $10 - 3801$ In	death (Item 23a) (Ty ternatio	pe, Print) nal Drive	, #211, St	llver Spr	Lng,MD 2090)6
State Registra	7	31. Date filed (Month, Day, Year) JUN 2 8 2	2011 2. Registr	ar's Signature	ales				

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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any		10a. State	10b. County		10c. City,	Town or Loc	cation							10d. Inside City Limits
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arylan 8a-f s	윉	10e. Street and No			1		10f. Zip	Code			10g.	Citizen	of What Cou	ntry?
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with t	<u>ra</u>	11. Marital Status		12. Was Deceden		S. 13. V	Was Deced	ent of Hisp	anic Origin? Mexican, Pu	(Specify	Yes or No-		Race - Amer White, etc.	ican Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeria. In the Maryland Important. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Di				Place of Disp crematory or			etery,	Da	te 2	20c. Loca	ation - City o	r Town, State
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SiO Atten r deatl ector:	Certification:	2 🗸 Accident	Investigat	28e Place of	Injury - At I	nome, farm,	street, facto	ry, office b	uilding, etc.	28	f. Location (St	reet and	Number or F	Rural Route Number, City
Divi al or s after al Diri	\(\bar{2}{2} \)	3 Suicide	6 Could not determine	t be			J. J. J. J. J. J. J. J. J. J. J. J. J. J	.,,	J,		or Town, Sta 100 Dille Dri	ate)		
lospit t hour uners				clan: To the best of			ccurred at t	he time, da	ate and place	e, and due	e to the cause	(s) and r	nanner as st	ated.
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by their	Medical	(Check only one) 2	✓ Medical Examine	er: On the basis of e	xamination	and/or inves	tigation, in	my opinion	, death occu	rred at th	e time, date a	nd place	, and due to	the cause(s)
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6		(a	408 H	fllOa	11			O.C.I	M.E.			June	22, 2011	
		30. Name and a	ddress of person who											
		Carol Alla		ant Medical Ex			-	e Street,	Baltimor	e, MD 2	21223			
	State	31. Date filed (M	JN 2 8 2011	32. Regis	trar's Signa	ture	Red.							
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Registrar

			For State AND DUICO 4					lealth and N	/lental Hy	giene Reg. N	2611	22329
			1 - State Registra AMEND#28a/k		LT; HW, M	POD-EI	inicate of	—————	2. Date of De			3. Time of Death
	Physici		ALICE MARIE MY						Month 06/23/	/201		1603 ^M
-	/Medic Examin		4a. Facility Name (If not institution)		4b. City, Town, c	or Location of Death	00/ = 0/		. County of Dea	
1			618 N. Horners				Rockvil				Montgame	
П	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)		thplace (State or Foreign buntry)
	Director		142-22-2082 Usual Residence of Decedent		82				11/20	/28	Vir	ginia
	yland how		10a. State 10b. County	1	10c. City,	Town or Lo	cation			_		10d. Inside City Limits
	Ba-f s	ctor	MD Montg	omery	Rock	ville						1. Yes 2 □ No
	or 28	Dire	10e. Street and Number	_			10f. Zip Code				itizen of What Co	ountry?
	72 hours after death with the Maryland hatural", or Items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	618 N. Horners		Function I.I.C.	12.1	20850	Jinnania Origina (Co	acif. Van av Na		SA	viona Indian
	ter de	Fun	11. Marital Status 1 ☐ Never Married 🌠 Mai	12. Was Decedent Armed Forces? rried 1 ☐ Yes 2X	?	13. 1	Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	,	14. Race - Ame Black, Whit	
036	urs at	þ	3 ☐ Widowed 4 ☐ Divorce	If Yes Give		1	□Yes ¾☐No	Specify:			Specify:	lack
21215-0036	72 ho	Completed	15. Deceder	nt's Education		(Give	lent's Usual Occup	during most of work	ina	16b. K	Kind of Business	
121	/ithin ine. han "	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. L	DO NOT use retire	d)				
	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle	Last)		Nurs.	ing Assis	18. Mother's Nam	e (First, Middle		sing Ho	me
an	ental ental ked o	To Be	Laffale Nelson					Grace Ro			ŕ	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailin	g Address (Street	and Number or Rui		er, City	or Town, State,	Zip Code)
Σ	s 1 and 2 strand 2 strand 2 strand 27 is		Martin Myers /	husband		618 N.	Horners	Lane,Roo	kville	Md	20850	
Baltimore,	jes 1 t of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Pla	ce of Dispo netery, cren	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
tim	t. Pag tment tant: ijury o		4 □ Donation 5 □ Other (Specify)			ematory		/2011	Han	over, M	D
Bal	permil Depar Impor any Ir once.		21. Signature of Funeral Service	/	.001		. Name and Addre	Sr			ral Home	
			23a. Part 1. Enter the disease, of		1576			shington S			le, MD	Approximete
	Dhusisian		shock, or heart failure. Lis Immediate Cause (Final	stonly one cause on each li	ine.				or roop, actory o			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Rupture Due to (or as	d Abdo	omina]	Aneurys	s m				2 days
15	Examiner		On a constitution line and distance	b. Hyperte	ngion	,						20 years
	B :	iner	Sequentially list conditions, if dry, each glown in a data cause. Enter Underlying	Diffe to (or as	a donawouni	noi eth						
	and I-tra	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
68760,	ficate be executed physician and s the burial-tra sit	ig E		330 10 (8) 23	o do neo que							
687	tificate g phy as the	edicat		d								
Вох	law requires that the death certific as been signed by the attending p 2 should be detached for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	C)/			23d. Date of de	
О. В	e deal	sicis	in the past 12 months? 1 □ Yes 2 🔀No	4 Pregnant a			Other (specify) _				Month	Day Year
P.	that the de ned by the a detached f	Phy	9 ☐ Unknown Part II. Other significant condit		but not regulti	ing in the ur	derlying cause give	van in Part I	23e Did	tohacco	use contribute t	o the cause of death?
ds,	signed signed be det	ğ	Breast Cancer	ions contributing to death t	but not result	ing in the di	locitying cause git	verriir r art i.		Yes 2		robably 4 Unknown
Records,	w requir s been s should	Completed	Ol-i O core						24a. Was		1	utopsy findings available
Bě	The law ate has page 2 s	Jmp	Skin Cancer						auto perfo	psy ormed?	prior to death?	completion of cause of
	an: T tifficat tor, p?	Be Co	25. Was case referred to medica	al				26. Place of Deat	1 □Yes		o 1∐Ye	s 2 No
Ţ	nysici nis cer direct		examiner? 1 □ Yes 2 🙀 No	Hospital:	ient 2 🗆 El	R/Outpatien	t 3 DOA Ott	207			6 ☐ Other (Spe	ecify)
n 0	ng Pt	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of Inj ng (Month, Da	ury 2 ay, Year)	28b. Time of Injury	28c. Inju Woi	ry at rk?	28d. Describe	how inju	iry occurred	
sio	tendi feath. tor: A	cati		ligation 06/23/		16:03	-	Yes 2 11 No				
Division of Vital	or At after c Direc	Certification: To		mined 286. Place of In	tc. (Specify)	ie, tarm, stre	eet, factory, office		City or To	Street a wn, Stat	nd Number or Fi e)	Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 but on after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1X Certify	ing Physicians To the best	t of my knowl	ledge, death	n occurred at the t	ime, date and place	, and due to the	e cause(s) and manner a	as stated.
	n 24 h	Medical	(Check only 2 Medica	Examiner: On the basis of and manner s		on and/or in	vestigation, in my	opinion, death occu	rred at the time	, date ar	nd place, and du	e to the cause(s)
	withi To th	Ř	29b. Signature and title of certific	er -		\	29c. Licens	se number		29d. Da	ate signed (Mon	th, Day, Year)
	2		John	A & Me	10 1	43	D081	L07		04	e/25/	2011
			30. Name and address of person	1	/			Montagna :-	, 17:11-	70	MD 3000	6
	Sta	te	31. Date filed (Mörith, Day, Year					Montgomery	v viita	ye,	LT 2008	0
	Registr		JUN282	2011 Sendera	rar's Signatu	gar	507					

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amend item 25 per me g918 8-3-11 vt.
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar 22330 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE Day 2011 Physician/ 20 CHARLES MERTON MILLER 9:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 8. Date of Birth (Month, Day, Mar 5, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours 1921 Mary land 90 220-16-0876 **Director** Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director New Windsor Carroll Maryland 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21776 Funeral 1300 Tibbetts Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner r Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Specify: 3 Widowed 4 Divorced e or nit. Page 1 and 2 should be filed within 72 hours a equitment of Health and Mental Hygiene.

In ordant: If item 27 is marked other than "natural" on injury or other traumatic event, the Medical Exconce. Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ഉ Clara Poole Robert H. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Holland Lane, Westminster, MD 21158 Rita Holland, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Pipe Creek Cemetery 1 X Burial 2 Cremation 3 Removal from State 6/24/2011 Linwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine bus to (or as a consequence of, CALEXAMINER Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit CERTIFICATION APPROVED BY and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending r should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate Yes 2 No 25. Was case referred to predical 26. Place of Death (Check only one) director Be examiner? Other: 1 X Yes ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To After this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Mann f Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Investigation work?
1 Yes 2 No 1 Natural Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) reloz AYE Sa 20 MDH 64135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Safrina Frederick, MD 21701 400 W 74h Hasan

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Registrar

31. Date filed (Month, Day, Year)

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32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Item 26 per med cert State of Maryland / Department of Health and Mental Hygiene 22331 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 A M 0300 Virginia P. Marcus Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil E1kton Union Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours Min. April II, 1918 Maryland 218-07-8799 93 Yrs Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎇 No Maryland Ceci1 E1kton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 Norman Allen Street 21921 United States items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. sand Mental Hygiene.
Is marked other than "natural", or iter-raumatic event, the Medical Examiner. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. ဂ္ Ethel Blanchfield William H. Purdy, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith F. Tanner/Daughter 495 Black Snake Road, Elkton, MD Date 7, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State Elkton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 201] Elkton, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SHOKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Mid-Cerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown cate has been signed by the atte page 2 should be detached for Dav Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CAYdismyopATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed ungestive Heart Railure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy Renal Jusufficience Chronic 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 24 hours after death. completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ 1 Inpatient 2 ER/Outpatient 3 DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 □ Suiciae 4 □ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nursé Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

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29b. Signature and title of certifie

Two thy

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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29c. License number

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29d. Date signed (Month. Dav. Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** MARGARET D. MASSEY 26, 2011 12:45 A June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** Somerset McCready Memorial Hospital Crisfield If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 10/31/1921 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖫 89 Director 218-07-3966 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State r 28a-f show notified at Yes 2 No Maryland Crisfield Somerset Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or than "natural", or items 23a or the Medical Examiner must be 21817 U.S.A. 5 Potomac Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 ☐ Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MD State Unemployment **Employee** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olen Daugherty Carrie Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) P. O. Box 219 - Bellvue, Colorado 80512 Christine Allender (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of I Important: If Ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Mem. Park | 06/28/2011 Crisfield, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Janeral Service Lie 64 306 W. Main St. - Crisfield, Robert H. Bradshaw, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MYCCARDIA ACUTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examine certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the at a detached fo P.0. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 → To 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy performed? 1☐ Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Momicide

To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital of within 24 hours af To the Funeral D

R SATYAL, MI) 31. Date filed (Month, Day, Year) Registrar

29a. Certifier

Medical



29c. License number 0 62172

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 6/26/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(604 MARKET ST POLOMOKE CITY ND Z1851

32. Registrar's Signature

Danny Hubert Milligan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day June 29, 2011 Medical Examiner Milligan 0556 hrs Hubert Danny 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13002 Spickler Road Clear Spring Washington 5. Social Security Number If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Months Days Hours Director 260-84-2670 1X M 2 F 63 Oct. 6. 1947 Country)Georgia Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No or items 23a or 28a-f shovenst be notified at ooce. MD Washington Clear Spring more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 13002 Spickler Road 21722 U.S.A. Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1X Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White event, the Medical Examiner. "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Forklift Driver Warehouse 17. Father's Name (First, Middle, Last) 8.Mother's Name (First, Middle, Maiden Surname) Be Troy Hubert Milligan Vivian Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda C. Milligan/Wife 13002 Spickler Rd., Clear Spring, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1 Buria! 2 X Cremation 3 Removal from State Smithsburg Crematory 7/4/2011 Smithsburg, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral S Pennsylvania ave., Hagerstown, 23a. Part I. Enter the disease, or complicat ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval **Physician** failure. List only one ceuse on each Between Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or es e consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause a or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED e attending physician for use as the burial -Records, P.O. Box 68760, The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached for Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been sector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No Division of Vital Fital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural Jun 29, 2011 Subject fell from stairs 0545 hrs Pending 1 Yes 2 ✔ No hours after death. the Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 13002 Spickler Road, Clear Spring, MD 4 Homicide determined To the Fuoeral (Specify) Single Family Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number June 30, 2011 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Regis

State Registrar

To the I within 2 To the I

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DANIEUE DOBERMAN, MD

Box (

of Vital

Registrar DHMH 17 Rev 7/2009 D64395

JUNE 20, 2011

CEDAR LANE COLUMBIA, MD 21044

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Registra AMEND#29doenMD, 6/29/11: BMV, MoCo Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27, Day 2011 Year JuMoeth 0scar Nitz 2:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Alfred House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M M 2 □ F Days Hours Country) Poland June 2 Pay, 1934 77 Director 291-38-1067 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Olney 10d. Inside City Limits with the Maryland Director MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18624 Woodgate Place 20832 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 ₺ Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Worker pernit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important. If item 27 is marked other ti any injury or other traumatic accent General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Nitz Anna Ritter 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $18624\ \ Woodgate\ \ Place,\ \ Olney,\ \ MD\ \ 20832$ Katherine A. Nitz/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 Burial 2 ☐ Cremation 3 Removal from State July 201 Standing Rock Cemetery 4 Donation 5 Other (Specify) Kent. Ohio 21. Signature of Funeral Service Licensee 22 Name and Address of Facility as Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Progressive Supranuclear Palsy Sequentially list conditions, It any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of a that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Contract Con in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No g Unknown a Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires Division of Vital Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed Yes 2 certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTED LIVING examiner? 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral director. 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and di date and place, and due to the cause(s) and manner stated due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year, Thernational Drive, Silver Spring, 30. Name and address of Gary Landon, MD 20906 31. Date filed (Month, Day, Year) State JUN 2 8 2011 Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc g917 7-19-11 vt State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

9:08 am

10d. Inside City Limits

Approximate Interval Between Onset and Death

reaks

Year

USA

1 Yes 2 □ No

Division of Vital Records,

Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Mknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes Assisted 6 Dother (Specify) Living Certification: To 28d. Describe how injury occurred Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) itle of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Riedinger, M.D. 8601 Veterans Highway Millersville, MD 21108 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 8,2011 Physician/ **EMANUEL** PETRELLA 3:45A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CHARLES 9825 PENNS HILL ROAD LA PLATA Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X** M 2 □ F Months Hours 4-22-1933 578-40-9235 78 OHTO Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director LA PLATA 1 🗆 Yes 2 🔀 No MD. CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9825 PENNS HILL ROAD Funeral 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No NAVY
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced KOREA Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) BUILDINGS MANAGER U.S.GOVT. 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TERESA DeMARCO GIOVANNI PETRELLA 19a. Informant's Name/Relationship (Type, Print)
JOHN PETRELLA-SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $15115\ GANLEY\ RD.\ BOYDS$, MD. 2084120c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date ST. MARY S CEM. 1 KBurial 2 Cremation 3 Removal from State 7-11-11 NEWPORT, MD. 4 ☐ Donation 5 ☐ Other (Specify) M004RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Betwee MESOTHELIOMA Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months? Day Month Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Kunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, value and phases and phases and phases and phases and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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death v items		11. Marital Status		12. Was Decedent		S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		14. Race - Ameri Black, White,	can Indian,
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Alan Peig	me/Relationshi	p (Type, Print) (Son)				and Number or Ru				Code)
Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disp 1	X Cremation	3 ☐ Removal from State		emetery cren	sition (Name of natory or other place g Cremat	ory 7/8/	Date 2011		ocation - City or T thsburg,	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	Ectopic pregnand Other (specify)	су			23d. Date of deliv	very Day Year
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vttending death. ctor: Afte y the fun	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investiga 6 ☐ Could n	ot be		injury	M 1 □	Yes 2 No	29f Location /	Ctroot an	d Number or Rura	al Pauto Number
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e Hospi 24 hou e Funer	Medical	(Check 2	Medical Ex	Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	xaminatio	n and/or invest	igation, in my opinic	on, death occurred a	at the time, date	and place	e, and due to the ca	ause(s) and manner stated
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DHMH 17 Rev 7/2009

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	Physicia		1. Decedent's Name (First, Middle, Last) Vicki Lynn Peel				. Date of Death	011 Year	3. Time of Death 5:30 AM M
	Medio Examin		4a. Facility Name (if not institution, give street and number) 542 Logan Street		4b. City, Town, or Freder	Location of Death		4c. County of Death Frederick	
	Funeral Director			ge (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea	9. Birti	nplace (State or Foreign ntry) ryland
		ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits Y Yes 2 \(\text{No} \) No
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960	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Never Married 2 Married 1 Fyes, Give Year or Dates.	XNo.		spanic Origin? (Specify n, Mexican, Puerto Ric		14. Race - Amer Black, White Specif White	etc
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Maryland 2	d be filed w Aental Hygi irked other itic event, i	To Be	17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name (F Margaret	irst, Middle, Maid Boyer	en Surname)	
	nd 2 should ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) John W. Peel III, Husband	19b. Mailir 542	ng Address (Street a Logan St	reet, Frede	oute Number, City Prick, M	or Town State, Zip 21701	Code)
Baltimore,	Page 1 arment of He tant: If iter iury or oth		20a. Method of Disposition 1 🔀 Burlal 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposer Cemetery Cremetery Cremetery Cremetery Cremetery Cremeters Coling	esition (Name of matory or other place ret Cemete	ery July 1	1, 2011	. Location - City or Frederic	
Balt	permit. Depart Import any inj once.		21. Signature of Funeval Service Licensee	00255	Name and Address eeney and 06 East (f Basford F Church St.,	PA Funera Freder	al Home ick, MD 2	1701
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3760	ificate bo ig physic as the b		d						
Box 68	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/N		2 Fetal death 3 at time of death 5	Ectopic pregnand Other (specify)	ey		23d. Date of deli Month	ivery Day Year
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Division of Vital Records,	The law require ate has been si bage 2 should	omplet					24a. Was an autopsy performed	prior to d	copsy findings available completion of cause of
/ital	sician: certifica irector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	tient 2 ER/Outpatie	Oth	ace of Death (Check or	nly one)		
on of \	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ury 28b. Time of	28c. Injury work	y at 28d	d. Describe how in		19)
Divisio	al or Atte s after de: al Director ed in by th	I Certificate:		jury - At home, farm, str tc. (Specify)	eet, factory, office	28	f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
	he Hospit iin 24 hour the Funera	Medical	29a. Certifier (Check conly one) Certifying Physician: To the best of the deck only one) Certifying Nurse Practioner: To the	examination and/or inves	tigation, in my opinio	on, death occurred at the	e time, date and pl	ace, and due to the o	cause(s) and manner stated
	To t vith		29b. Signature and title of certifier	ND	29c. License	number 27931	29d.	Date signed (Month	
	P. A.		30. Name and address of person who completed cause of Sebastien S. Kairouz, N	death (Item 23a) (Type, I 1.D., 46 Th	omas John	son Drive,	Frederi	.ck, MD 21	L702
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist 13. 2011	ar's Signature					

DHMH 17 Rev 7/2009

lames Peterson		- For State Registrar	tate of Maryla		epartmo C <i>ertific</i> a			Mental I	-	leg. No.	20		22340
Physician Medical Examine	1	1. Decedent's Name (First, Midd James J. Pet							2. Date of Dea Month June 19,	Day	Year		3. Time of Death 0056 hrs
		4a. Facility Name (if not institution Bon Secours Hospita	on, give street and nu	umber)		4	b. City, Town, or L Baltimore	ocation of Dea			c. County of		
Funeral Director		5. Social Security Number 216-22-2562	6. Sex	7. Age (In y		hday) 1 Yrs.	If Under 1 Year Months Days	If Under 24H Hours M				Foreigr	nplace (State or n Pryland
r any	_	Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town	or Location	on						10d. Inside City Limits
Maryland 28a-f show		[aryland] N/	A		Ba1	cimo	re 10f. Zip Code		1	10g. Cit	izen of Wha	t Coun	1 Yes 2 No
r death with the Maryland or items 23a or 28a-f sh wust be notified at onc	<u> </u>	11. Marital Status	st Park	cedent Ever i	in U.S.		212 Decedent of Hisp	anic Origin? ()-		Americ	an Indian, Black,
s after death ral", or iten		1 Never Married 2 X M 3 Widowed 4 Div	Armed F 1 X Yes vorced If Yes, Give Yes or Dates:	2 N			es, specify Cuban, i		to Rican, etc.)		White, Specify:	etc. B 1 a	ack
2 hour "natu	naiair	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (de completed	d) 16a. l	during ma	s Usual Occupationst of working life. I				Kind of Busi		·
MD 21215-0036 d 2 should be filed within 7 d 1 sund Mental Hygene. n 27 an marked other than numatic event, the Medical		12th 17. Father's Name (First, Middle	•			F	itter		ne (First, Middle,	Maiden	Koppe Surname)	r's	5
John Peterson Nary McGowan 19a. Informant's Name/Relationship (Type, Print) Rethea M. Peterson(Wife) 2503 W. Forest Park Ave Balti:													
ges 1 and 2	Ī	20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal fr	om State	0b. Place o cremate	f Disposit	ion (Name of ceme er place)	etery,	Date	20c.	Location - 0	ity or 1	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr		4 Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee		ALTII	2W 11	n Natio ආංදෙ 22_Fore	of FacilitySon	ns Mort	uaı	ry, P	. A	
Physician /Medical	1	23a. Part I. Enter the disease, or failure. List only one cause	on each line.			t enter th	e mode of dying, sovascular Dise	uch as cardiac	or respiratory an	rest, she	ock, or hear	u.	Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a			Carai	Traduction Disc						
		if any, leading to immediate cause. Enter Unidenying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a										
D, be executed be executed sician and untal - transit		UNPENDED	dAMENDED			_							
		IF FEMALE: 3b. Was decedent pregnant in to past 12 months?	he 1 Live t	outcome of pointh	2	=	al death 3	Ectopic pregr	nancy	23	d. Date of d Month	elivery Da	 ay Year
O. BO. at the deat d by the at stached for		1 Yes 2 No 9 Un	known 9 Unknowns		not resulting	in the ur	nderlying cause giv	ren in Part I.	23e. Did t			_	ne cause of death?
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 burus after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the today of the completely filled in by the funeral director, page 2 should be detached for use as the today.	December								24a. Was auto	an	24b. We	ere auto	opsy findings available ompletion of cause of
cian: The law certificate has ector, page 2 sl		25. Was case referred to medica	н				26.Place o	of Death (Chec	1 ✔ Yes	rmed? 2 N	lo 1	ath? / Yes	2 No
of Vitaing Physici	≥ ₋	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury		itpatient Fime of In			ing Home 5			Other:	
Division of 'To the Hospital or Attending Phwithin 34 hours after death. To the Funeral Director: After tompletely filled in by the funeral	uncano	3 Suicide 6 Cou	ding stigation Id not be		At home, fa	rm, street	1 Ye	s 2 No	28f. Location (and Number	or Run	al Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide 29a. Certifier 1 Certifying P (Check only	hysician: To the beaminer:On the basis	st of my know	_								
To the Ho within 24 To the Fu Completel	Med	29b. Signature and title of certific	and manner s				29c. License O.C.M	number		29d.		(Mon	th, Day, Year)
LVA		30. Name and address of persor Ana Rubio MD. As:	who completed cau			/ Raltie			ID 21223	1 ""			
Stat Registra	-	31. Date filed (Month, Day, Year)	32. R	gistrar's Sig		4	Was Street, B	ailimore, IV					
Registra	ш.	JUN W		And the same		F							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** alvin 2011 93 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Mailard Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Months Hours 1 M 2 □ F 0 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ Wo Director 10g. Citizen of What Country? 10e, Street and Numbe by Funeral 12. Was Decedent Ever Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. in U.S. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216.75 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Jown, State 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility omiesell 2-1613 Home Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death 23a. Part1 Enter the disease, Immediate Cause (Final disease or condition resulting in death) dementia **Physician**)4*ea*vs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Et al. J. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Day in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) P.O. ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XNO Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

1012 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson

29c. License number

Cambridge, MD

29d. Date signed (Month, Day, Year)

123

within 2 To the I

Peritz, Dorothy 6/21 1341 Am Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c,e,f per fh g927 5-31-12 vt. State of Maryland / Department of Health and Wental Hygiene 2011 For State Registrar 22342 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 21 Physician/ Dorothy Peritz 1341 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Surburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months March 13, 1910 101 Massachusetts Yrs **Director** 196-01-4898 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State **Florida** 10b. County 10c. City, Town or Location Director Broward Hallandale Beach 1 Yes 2 X No Maryland Montgomer 10e. Street and Number 320 NE 12th Ave. 10f. Zip Code 10g. Citizen of What Country? 33009 Funeral U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 δ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. item 27 is marked other than "natural", other traumatic event, the Medical Exai Specify Completed 3 X Widowed 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Store Owner Retail/Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ! 'is marked or ည Jacob Garber Jennie Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Jules Meisler - Nephew 11411 Monticello Avenue, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lakeside Memorial Pk 06/23/2011 Miami. Florida 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MISIO woon 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ Acute Hypoxic/Hypercapnic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Respiratory Failure Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on Pleural Effusion resulting in death) Last Due to (or as a consequence of) physician at the burial-Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year signed by the a 1 Yes 2 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Congestive Heart Failure 1 Yes 2 X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Acute Renal Failure 24a. Was an page 2 s performed within 24 hours after death.

To the Funeral Director, After this certificate completed filled in by the funeral director, pag Thrombocutopenia 2 🗌 No Yes 2 X No To the Hospital or Attending Physician; within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 🗌 Yes ည 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title 10 068405 NEWALV erson who completed cause of death (Item 23a) (Type, Print) Jesus David Guevara-Nieto, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

State

Registrar

1. Date filed (Month, Day,

JUN 27

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		State of Maryland / Department of Health and Mental Hygiene													
			State Registrar			Cer	tificat	e of D	eath			Reg. No.	ALL	25	231.3
	Physicia	ın/	Decedent's Name (First, Middle, La	est)	T	2001	1.	. 1			Date of Dea Month	ath Day	3 2001	3. Tin	fie of Death
. N	Medic	cal	4a. Facility Name (if not institution, giv	a street and supplied	(H5 1	101	<u>U</u>			0	2:	2 2 7		7 A. M.
	Examir	ier	Tate Hospice Hous				Li	nthic					nne Aru		
	Funeral Director		5. Social Security Number 6. \$ 212-68-2522	Sex 7. Ag		ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day July 5	h ', Year)	9. Bir	thplace (St untry) rela 1	tate or Foreign
			Usual Residence of Decedent		88						July 5	, 192		тета	.Iu
	/land f sho	tor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation								de City Limits
	Man, 28a- notifie	Director	MD Anne Art	ındel	Anr	napolis								L	Yes 2 X No
	ith the	ral	10e. Street and Number	1 / 202			10f. Zij	Code 403				10g. Citiz	en of What Co ' US		
	ems 2	Funeral	933 Edgewood Road	12. Was Decedent	Ever in U.	S. 13. V			spanic Orig	in? (Spec	ify Yes or No-	14	4. Race - Ame		ın.
9	ter de , or it imine	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣	No	11	Yes, spe	cify Cubar	n, Mexican, Specify:	Puerto P	ican, etc.)		Black, Whit		,
8	urs af tural" al Exa	Completed	3 🛚 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.								S	pecify:	Vhite	
15. Decedent's Education 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Specify only highest grade completed) (Fig. DO NOT use retired)								of workin	g	16b. Kin	d of Business	Industry			
212	led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or 1	5+)	_	wner	o retired)				Re	etail		
Maryland 21215-0036	tal Hy	To Be	17. Father's Name (First, Middle, Last)	ar							(First, Middle,	Maiden Su	ırname)		
ryla	ld be Men arke	-	Jack Jaffey	T D :- 11		1					Cohen	-			
Ma	shouth and hand hand hand hand hand hand hand		19a. Informant's Name/Relationship (Felice Cohen (day			T	-	•			Route Number tepasi	-		-	eland
ē,	1 and 2 s of Health item 27 other tra		20a. Method of Disposition			Place of Dispo	sition (Nar	ne of			ate		ation - City o		
m	Page nent c ant: If ary or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			emetery, cren 1g Davi				6/24,	/2011	Fal:	ls Chu	cch,	VA
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licer	see							desty			ne P.	Α.
	<u></u>		19 9. Jun	- P - P 1 - 1							napolis		21401		
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line	a the deat e.	n. Do not ente				cardiac or	respiratory arr	est,			ximate al Between and Death
	Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	Jence of:	TF	ALL	WE						
Span	Examiner	L	Sequentially list conditions,	CHE		·									
	at a	Examiner	if any leading to immediate cause. Enter Underlying	Due to or as				=h.e		-					
	ecute and I-trans	zxan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (a) as	a consequ	DiAL uence of):	100	MK (en sy	<u> </u>					
0	death certificate be executed ne attending physician and ed for use as the burial-transit	edical				CNS1	ON								
3760	ificate ig phy as the	Medi	IF FEMALE:	- d											
Box 687	th cert tendir or use	ian/I	23b. Was decedent pregnant in the past 12 ponths?	23c. If yes, outcome 1 Live Birth	2 Feta	al death 3			/			23	3d. Date of de		V.
		Physician/M	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	at time of o	death 5∟	Other (sp	pecify)					Month	Day	Year
P.0.	that the ned by the detach	by Ph	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	nderlying	cause give	en in Part 1.		23e. Did to	bacco use	e contribute t	the cause	of death?
JS,	uires an sign	ed b									1 🗆 🕆	Yes 25	No 3□F	robably	4 🗌 Unknown
Sor	aw rec as bee 2 sho	Completed									24a. Was a				ings available n of cause of
Re	The Is	Соп									perfo	rmed?	death?	s 2 🗆 No	
ital	certific	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	-			Othe	ce of Death		-			<u> </u>	
of V	Physer this eral di	e: 10	27. Manner of Death	28a. Date of inju	iry	ER/Outpatien 28b. Time of		OA Durio	4 ∟ Nur		ne 5 🗌 Resid 8d. Describe h			ify) HO	spice
ono	ending sath. rr; Afte	ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		y, Year)	injury	М	work?	Yes 2 🗆	- 1					
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ury - At ho	me, farm, stre	et, factor	y, office		2	8f. Location (S City or Tow		Number or Ru	ral Route N	Vumber,
Ξ	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be		29a. Certifier 1 Certifying Phy	vsician: To the best of	my know	ledge death o	occured at	the time	date and n	place and	due to the co	ise(s) and	manner as at	ated	
	ne Hos n 24 h ne Fun pleted	Medical	(Check 2 Medical Exam	niner: On the basis of e	xaminatio	n and/or invest	igation, in	my opinior	n, death occ	curred at t	he time, date a	nd place, a	and due to the	cause(s) an	d manner stated.
_	Voithi To th		29b. Signature and title of certifier	/				. License					signed (Mont		ır)
			Tou Jus	hens 1	nus			177	236	0		612	3/11		
d	45		30. Name and address of person who Lou Lukas MD 445			, , , , ,		MD 2	1401						
¥	Stat	e	31. Date filed (Month, Day, Year)	32. Regietra			/				_				
	Registra		.IIIN 2 4	2011 12.	MARI	19.	Mark								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month (08114M Physician/ UMTER Medical Town, or Location of Death County of Deat 4a. Facility Name (if not institution, give street and number Examiner BINTIMORE WASHINGEN MEDICAL GIEN BURNIE If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 🕅 M 2 🗆 F July 9 ay, South Carolina ′1°927 83 496-20-4686 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Anne Arundel Maryland Gambrills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21054 1403 Wigeon Way Unit 307 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manager of Government Affairs Olympic Airways Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental In Important; If item 27 is marked any injury or other Maud Ella Markin Sumter Allen Porter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1403 Wigeon Way Unit 307 Gambrills, MD 21054 Joy A. Porter/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Baltimore Washington 7/2/2011 1 Burial 2 X Cremation 3 Removal from State matory 7/2/2011 Laurel, MD
22. Name and Address of Facility Robert E. Evans Funeral Home 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Examir The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 2 🗌 No 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has performed? within 24 hours after death.

To the Funeral Director, After this certificate t completed filled in by the funeral director, page 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatu

State Registrar of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	for AMEND#31 Per HD State of Maryland / L State Registrar 6/27/2011 AACO HEalth Dept. OMH	Certifica					2011	22345		
			Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death		
	Physicia Medic		Raymond Parker				June	18	20 ^{Year}	10:35A M		
	Examin		4a. Facility Name (If not institution, give street and number)	4b. C	•	Location of Death		- 1	. County of Deatl			
ment to	,		275 Whitaker Rd.	7 1 161 (a	Pas der 1 Year	adena If Under 24 Hrs.	8. Date of Bir		Anne A			
	Funeral Director		214-44-2224	Yrs. Monti		Hours Min.	Aug 2	y3 ^{Year} 1	945 Ma	hplace (State or Foreign Lyland		
	yland •f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town			-	-	-		10d. Inside City Limits 1 ☐ Yes 2 🌠 No		
	e Mar r 28a notifi	Oire	Maryland Anne Arundel Pasad 10e. Street and Number		Zip Code	·		10a Ci	itizen of What Co			
	ith th	Funeral Director		101.	211	22		iog. Ci	USA	and y i		
	ems r	nue	275 Whitaker Rd. 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was De		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		14. Race - Ame	rican Indian,		
036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give Year or Dates.		pecify Cubar s 2 ∏ No		Hican, etc.)		Black, White	e, etc. lack		
Maryland 21215-0036	72 hour	Completed by	(Specify only highest grade completed)	Decedent's U (Give kind of life, DO NOT	work done di	ition uring most of work	king	16b. k	Kind of Business	Industry		
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p	filed all Hy d oth	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										
Уa	Ment Ment arke	잍	William A. Parker			Margar						
Nar	and 2 should be fi Health and Menta Item 27 is marked other traumatic ev		l			nd Number or Rur						
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Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	rial :	Park	6-2	7-11	An	napoli	s, Md.		
Ba	Depar Depar Impor any in		21. Signature of Funeral Service Licensee	192	2 For	est Dr.	Annap	01i				
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3876	rtifical ling ph e as th	₩ We	IF FEMALE:									
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 9 ☐ Unknown	3 Ector 5 Othe	oic pregnanc r (specify)	у			23d. Date of de Month	Day Year		
O.	at the d by t fetach		Part II. Other significant conditions contributing to death but not resulting i	n the underlyi	ng cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?		
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oro	w request been some	Completed					24a. Was			topsy findings available completion of cause of		
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Ξ	al or A s after I Dire		4 Homicide determined building, etc. (Specify)				City or To	wn, State	e)			
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or	or investigation	, in my opinio	n, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated.		
	thin 2	ž	only one) 3		ccurred at the 29c. License		ace, and due to the	_	(s) and manner as ate signed (Monti			
0	F 3 F 8		man O. Welltons		Do	02374	-3		6-24-	-11		
7	141		30. Name and address of person who completed cause of death (Item 23a) (/	Paris	a CL	DE	10-	en hell	Un		
7	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	5 CHC	enwa	CAT	J1 C	,, 0	- COCI+	, - \		
	Registr	ar	6-24 JUN 2 7 2011 Denur B	. par	Jew -							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 25, 2011 1:15 Physician/ Рм Milton Eugene Parker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hyattsville St Thomas More If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day Yea
March | 13, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 2 M 2 □ F Months 83 DC 578-34-1608 **Director** Usual Residence of Decedent or 28a-f show notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Washington DC 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number ms 23a or Funeral United States 20019 4224 Southern Avenue SE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or item ledical Examiner n Armed Forces?

1 🔀 Yes 2 🗌 No Black, White, etc. þ 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced American permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) 7th Government Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Joseph Parker Julia Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4224 Southern Ave. SE Washington, DC Margaret C. Parker - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State Laurel, Maryland Maryland National 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licensee 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Seizure Disorder 1 Yes 2 No 3 Probably 4 X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Hypertension page 2 s performed Yes 2 Pneumonia funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 XNatural 5 Pending work 1 Yes 2 No Investigation Accident the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D0063681 June 29, 2011

State Registrar 20783

Hyattsville, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajit Kurup, M.D. 1835 University Blvd. E. Suite 208

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22347 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Month Ann Louise Poteet June 15 12:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 287 Powell Circle Berlin Worcester Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Days Hours 173-26-7109 01/06/1932 Director 79 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Worcester Berlin 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? ms 23a o Funeral 287 Powell Circle 21811 USA items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify. Completed White 27 is marked other than "natur traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Newton Dobelbower Louise Julia Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 287 Powell Circle, Berlin, MD 21811 Ann Runo/niece If item 2 or other t Important: If iten any injury 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 06 17 2011 Salisbury, MD 21. Signature of Funeral Sey 22. Name and Address of Facility. Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ess Immediate Cause (Final Onset and Death Physician/ Weta disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Due to (or as a consequence of). cause. Enter Underlying Exami burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE es, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year been signed by the sale 1 Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 sh 24a. Was an autopsy Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check o ly one) 2 Other: မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Dieth 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature 29c. License numbe 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

Name and address of person who complete

31. Date filed (Month, Day

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Olas

Pagistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death William Physician/ Quade 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner enesis Waldorf C Waldorf MD en If Under 1 Year | If Under 24 Hrs cial Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□M 2 □ F Months (Month, Day, Year) ne 29, 1920 90 Washington, D.C **Director** June <u> 220-05-5058</u> Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland Prince Georges Brandywine 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13706 Brandywine Road 20613 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces' Black, White, etc Yes 2 No U.S. þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 No Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates Coats Guard the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Iem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Coast Guard Secretarial 12th traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie T. O'Brien William C. Quade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6235 Quarles Rd. St. Leonard, MD. 20685 Deelaina Estep/ Daughter Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 5 1 Burial 2 X Cremation 3 Removal from State June 28, 2011 Waldorf, Maryland injury (4 ☐ Donation 5 ☐ Other (Specify) **Huntt Crematory** 21. Signature of Funeral Service icenses 22. Name and Address of Facility Huntt Funeral Home any 20601 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con-Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 9 Unknown 9 I Ilnknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an Physician: The law autopsy performe prior to completion of cause of death? page dney 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes |2 1 Inpatient 2 ER/Outpatient 3 DOA this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Hospital or Attending 1 Natural injury 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventioning in my spiritual death. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 71199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

DHMH 17 Rev 7/2009

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strar's Signature

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-Prive Annapolis, MD, 2140)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NICOL Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death **Examiner** HEDICK COX BALTIHOLE BAUTIHOLE NIVERSITY MALYLMD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreig 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 💢 F Days Months Min. 07/22/200 Country) MD 216-61-5140 Director 9 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 431 Taney Drive 21787 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11, Marital Status Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or i other traumatic event, the Medical Examin 1 X Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Student N/A 3 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shannon Nicole Qualls Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 21787 431 Taney Drive, Taneytown, MD Shannon Qualls/mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Cremat.: 07/29/2011 Woodbine, MD 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Ment 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MLHONALU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed EKEBRAL Due to (or as a consequence of): resulting in death) Last -burialattending physician Physician/Medical Box 68760 as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the a d be detached t g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? ZSWEEKS) EXTREME PREMATURITY 24a. Was an page 2: autopsy erformed? AS HEMMORLHAGE certificate INTRA VENTRICULAR NEONATE 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 001 MD my Kerrit

State Registrar MTOSICAL COM-

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JUN 23

31. Date filed (Month, Day, Year)

MARYLAND

			For State Registrar	State of I	Marylan		artment of H <i>rtificate of D</i>			iene 201	1 2	22350
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	Medic	al			ey				June June			12:45 PM
	Examin		4a. Facility Name (if not institution Encore at Tur)			tt City		4c. County of Howar		
	Funeral Director		5. Social Security Number 082–38–4810	6. Sex 1 \(\text{M} \) 2 \(\text{F} \) F	Age (In yrs. Ia 82	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth		9. Birthplac Country)	se (State or Foreign Spain
	nd how at	卢	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				10d.	Inside City Limits
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	a or 2 be no	٥	10e. Street and Number				10f. Zip Code	-		10g. Citizen of W		
	th with ms 23 must	Funeral Director	4501 Arlingto				2220			United		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status1 ☐ Never Married 2 ☐ Mar34☐ Widowed 4 ☐ Divorced	15 1/2 - Cine	No No		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🏿 No	n, Mexican, Puerto			- American k, White, etc. - Whit	
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Σ	nd 2 s ealth a m 27 i		Nancy Nolting/	daughter			Hunt Far	n Lane (Dakton,			
Baltimore, Maryland	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 4 ☐ Donation 5 ☐ Other (3			emetery, crei lent C	osition (Name of matory or other place rematory	6/28	Date /2011		er, Ma	ryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	Licenses Roman	M00957	1./1	2. Name and Address 112 Old Co	_{s of Facilit} Fiari Olumbia I	cy H. Wi Pike Ell	icott Ci	amily Lty, M	F.H. Inc D 21043
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live Birt 4 ☐ Pregnar 9 ☐ Unknow	h 2 ☐ Feta tattime of d	al death 3	Ectopic pregnancy Other (specify)	y		23d. Date Mor	e of delivery ath Da	ay Year
ls, P.O.	uires that the signed by ald be detained	by	Part II. Other significant condition DEMEN7 I		but not res	ulting in the I	underlying cause give	en in Part I.		bacco use contri 'es 2 🗌 No		cause of death?
Division of Vital Records,	Physician: The law req r this certificate has bee aral director, page 2 shoi	Completed							24a. Was a autop perfor	sy p med? / d	Vere autopsy rior to comp eath?	findings available letion of cause of
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	To the comp		29b. Signature and title of certifie	r			29c. License	number		29d. Date signed		
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	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth July 29	Year) 21	9. Birthp Coun Penn	olace (State or Foreign try) Sylvania
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003	ours af tural", at Exa	ted	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates.	., .	☐ Yes 2 🗓 No			Specif		White
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			30. Name and address of person who com N - S - Rayapakse, M - i	pleted cause of death (Ite	m 23a) (Type, P	s - 70	Bal	timore	MD	2120	59
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			Registrar 1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath		3. Time of Death
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	-		30. Name and address of person									
			Manish Agrawal					te 300,	Rockvill	e, Mar	yland	20850
	Sta Registr		31. Date filed (Month, Day, Year, JUN 2 7	2011	Registrar's Sign	A. bo	while.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Esfir Rodenberg 2019 1:00a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House 9. Birthplace (State or Foreign Country) Azerbaijan Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 1 □ M 2 🎗 F 08/30/1913 97 Director 214-25-7681 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Tes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1131 University Blvd. 20902 U.S.A. ural", or items? 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed Specify: 3 X Widowed 4 Divorced White Year or Dates of Health and Mental Hygiene, item 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Building Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Rodenberg Berta Rubenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vlada Kano - Daughter 19317 Dunbridge Way, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 06/22/2011 Olney, Maryland 4 Donation 5 Other (Specify) Judean Mem. Gardens : 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or co shock, or heart failure. List only oplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Obstructive Cholangitis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown Live Birth 2 Live Live Birth 2 Live Birth 2 Live of death Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day ned by the ar ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Dilated Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Aortic Stenosis autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 X No 2 🗌 No Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State; Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e D37142 June 21, 2011

Registrar

DHMH 17 Rev 7/2009

State

Geoffrey Coleman, M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 2 7 2011

			For State Registrar	State of Ma	ryland /	Departi Certifi	ment of F cate of L	eaith Death	and Me		giene Reg. No		22354	,
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Db Day Year 19 2011								3. Time of Death			
	Medic Examin		4a Earlith Name of not institution give street and number) 4b City Town or Location of Death 4c County of Death										_	
~ 4	Funeral	HI brow Home Of Great Nashing RO(KVIIIC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birthday									th		thplace (State or Foreign	_
	Funeral Director		578 – 28 – 9093	M 2 □ F 7. Age			onths Days	Hours		(Month, Da)2/12/	y, Year) 1916	Co N	untry) ew York	
	show dat	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location						10d. Inside City Limits					
	r 28a-f		MD Montgo		Bethesda 10f. Zip Code					10a C	itizen of What Co	1 X Yes 2 □ No	_	
	s 23a c s 23a c nust be	eral	7312 Greentree Rd.			'	01. ZIP 0000	2081	7		rog. Ci	US		
(0	or item	by Fur		2. Was Decedent Even Armed Forces? 1 X Yes 2 N	er in U.S. 1844	13. Was	Decedent of H , specify Cuba	ispanic Or ın, Mexica	igin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		14. Race - Ame Black, White		
0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ted b	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.			1 □ Yes 2 X No Specity:					Specify: White			_
215-		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business Industry			
121		Be Co	12 17. Father's Name (First, Middle, Last)	Outlings (1 4 of o r	′		Jewel		anda Namo (First Adiabats	Maidan	Jewe]	Lry	_
/lanc		101	Max Rosenberg						Esther	First, Middle, Wolf		Surriame)		
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship (Type						ral Route Number, City or Town, State, Zip Code)					
	of Healt of Healt fitem 2		Roslyn Rosenberg / 20a. Method of Disposition		20h Place	of Disposition	eentree		Bethe Da			.081 / .ocation - City or	Town, State	_
timo	it. Page rtment rtant: I njury or		1 X Burial 2 ☐ Cremation 3 X Ro 4 ☐ Donation 5 ☐ Other (Specify)				y or other place avid Gardens		06/22/			11s Chu		
Ba	Depa Impo any ii		21. Signature of Funeral Service Licensee	MOIL	17† Blake	Edwa	me and Address ard Sag l Rockv	el Fi	üneral Pike	Direc Rockvi	ctio ille	n Inc. , MD 208	852	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										Approximate	
	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	CONSEQUENCE	of):	Demo	nt	o de				5/1557 41/10 254411	_
	Examiner	er	Sequentially list conditions, b.	Due to (or as a consequence of):									_	
		Examiner	if any, leading to immediate cause. Er let Underlying Cause (Disease or linjury that initiated events c.	consequence	ioned diff.									
_	icate be executed I physician and s the burial-faster	sal Ex	resulting in death) Last	Due to (or as a o	consequence	of):								
8760	tificate t ng phys as the l	Medical	d.											_
0x 68	attending p	cian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								İ	23d. Date of de Month	elivery Day Year	
o M	t the de by the tached	d by Physician/M												_
Division of Vital Records, P.O. Box	ires tha signed d be de		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unkn										ı	
cord	aw requas been 2 shoul	Completed by	Hypertension.							24a. Was an autopsy findings availa prior to completion of cause			Itopsy findings available completion of cause of	
Rec	ysician: The la is certificate ha director, page												_	
Vita		To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Ho								Home 5 ☐ Residence 6 ☐ Other (Specify)			
n of	ding PI th. After th funeral	Medical Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation						8d. Describe how injury occurred					
/isio	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending formpleted filled in by the funeral director, page 2 should be detached for use as		2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
á			29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									ated.	_	
			(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner of certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									cause(s) and manner states stated.	∌d.	
	2 1/2 0/2		29b. Signature and title of certifier 29c. License number R 172412						112		29d. Date signed (Month, Day, Year) 6 / 2 0 / 1 / ,			
			30. Name and address of person who com	time and address of person who completed cause of death (Item 23a) (Type, Print) Alyson Timlin, CRNP E Jefelson St. Rockville, M.D. 208 S.Z. te filed (Month, Day, Year) JUN 2 7 2011 L. Registrar's Signature									<u> </u>	
	Stat	e	31. Date filed (Month, Day, Year)	50 √ 5 2. Registrar's	s Signature	ROC	RVII.	16,	MD	. 20'	8 5	۷.		_
	Registra	ır	.IIIN 2 7 2011	12. Due 1	A	BALL	A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 22355 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 201°1 Helen Louise Rothamer 1045 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Union Hospital Cecil Elkton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours Min OCI 20 Director 1933 IIIInois 328-28-3213 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? be Funeral iral", or items 23a Examiner must b 422 Gray Mount Circle 21921 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", Specify: White Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Fredrick Martin Elizabeth Boros t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore G. Rothamer/Husband 422 Gray Mount Circle, Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) ò 1 Durial 2 X Cremation 3 D Removal from State permit. Page Department Important: I R. A. Ferris & Co., Inc. 4 L Donation 5 C Other (Specify) 2011 West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SCOSYS Onset and Death Physician, CVA NSTEMI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ reclus 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes a No Other: 2 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

OLON HUSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2011

Registrar's Signa

29d. Date signed (Month, Day, Year)

FLILTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month Peter Romano 2011 Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death alis OMICO -the If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1**X**] M 2 □ F Days Hours (Month, Day, Year) 5-26-1944 **Director** 193-34-8530 Usual Residence of Decedent ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "--- any injury or other than the many injury or other than "---10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No DE Sussex Selbyville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 24 W. Mill Pond Drive 19975 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married 16+er Komano Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced spwhite Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Car Dealer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Spiros Romano Catherine Jacovidis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 W MillPond Dr. Selbyville, DE 19975 Rosalba Romano 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Evergr<u>een</u> <u>Cem</u> 6/23/11 Berlin, MD 22. Name and Address of Facility 917 W. 21. Signature of Funeral service Lice Isabella St. Bennie Smith Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death - Jako Physician/ Crentzfell disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Little underlying Cause (Disease or iinjury that initiated parts) Examine Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the uneral director, page 2.5 autopsy perform After this certificate 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) HOS 28a. Date of injury (Month, Day, Year) 27. Mapper of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one 29b. Signature ag title of certifie 29d. Date signed (Month, Day, Year) 00058410 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 1802 WAN 31. Date filed (Month

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death A CHOM Physician/ BEVERLY DRYDEN RAYNE Medical 4a. Facility Name (if not institution, give street and num 4c. County of Death **Examiner** 4b. City, Town, or Location of Death IN) (COMICO 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Country)
Maryl Director 219-44-1411 Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Crisfield Maryland Somerset 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 106 W. Chesapeake Avenue 21817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Baltimore, Maryland 21215-9 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist Cosmetology 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norris Robert Dryden Isabell Chelton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21817 Victor P. Rayne (Husband) 106 W. Chesapeake Avenue - Crisfield, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) \$unnyridge Mem. Park 6/25/2011 Crisfield, MD Mary Beth Bradshaw-Fruit 22. Name and Address of Facility BRADSHAW SONS FUNERAL HOME - Crisfield, MD 306 W. Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CREUTZFELDT *Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician Be Completed by Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2/ No Day Month Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence Cother (Specify) HOSPICA မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Accident Investigation 24 hours after deat To the Hospital or Atter within 24 hours after dec To the Funeral Director completed filled in by th 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) DO058410 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 SACY BURG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE EUGENE STEWART 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7230 SIMMS LANDING ROAD PORT TOBACCO CHARLES Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** , 1928 279-24-7697 1 3 M 2 F Months Days Hours Min. Country) **Director** 82 OHIO Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3126 GRACEFIELD ROAD 20904 S. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. KOREA 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALESMAN VA IMPRESSIONS PROD. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE STEWART EMMA SPYKER and 2 should the Health and Meter 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK STEWART/SON permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 9306 WILD GRASS CT., JESSUP, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JULY 1 Burial 2XXCremation 3 Removal from State METRO . CREMATORY 2,2011 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate n each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on burial-transit that initiated events resulting in death) Last to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown s been signed by the should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌠 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Physician: The 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \cancel{x} Other (Specify) DAUGHTER 1 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred RESIDENCEHospital or Attending 5 🗌 Pending Division Natural work 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Tes 2 \square No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) 3 [. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, 201

Registrar

State

31. Date filed (Month, Day, Year)

2066

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 6, 2011 Year Physician/ 12:01A_M CECIL DARRELL STANLEY Medical 4a. Facility Name (if not institution, give street and number, 4b City Town or Location of Death 4c. County of Death **Examiner** P.G. SOUTHERN MD.HOSP. CENTER CLINTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 4-14-1943 1 🔀 M 2 🗆 F VA . 231-56-3798 68 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County at 10a. State 10c. City, Town or Location Director must be notified MD. CHARLES WALDORF 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1901 BLACK OAK COURT 20601 U.S.A. items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black White etc 0 þ 1 Never Married 2 X Married Specify: WHITE 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 'natural", 3 Widowed 4 Divorced Completed Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) IRONWORKERS LOCAL#5 traumatic event, the IRONWORKER 10th Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ALVIN J. STANLEY OMA BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, NANCY STANLEY-SPOUSE 1901 BLACK OAK CT. WALDORF, MD. 20601 of Health a other! 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State o TRINITY MEM. GARDENS Department of Important: If any injury or once, 7-11-11 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M0.047Name and Address of Facility 21. Signature of Euneral Service Licensee RAYMOND FUNERAL SERVI 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician all street the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 5 Other (specify) Pregnant at time of death 2 No 1 Yes 2 9 Unknown the 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Nes 2 No 3 Probably 4 Unknown page 2 should need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to predica Be 26. Place of Death (Check only one) Hospita 2 No Other: 1 Yes 1 Inpatient 2 I ER/Outpatient 3 II DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Vatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Cartinyms Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date sibned (Mb

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22360 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18^{Day} 2011^{Year} Physician/ June 11:55 P M David V. Stouter Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Emmitsburg **Frederick** 16630 Annandale Road 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Davs Hours (Month, Day, Year) 1 XM 2 - F 42 213-02-4146 Director 1968 26. Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location the Maryland Director Examiner must be notified Emmitsburg 1 ☐ Yes 2X No Maryland Frederick 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral 23a IISA 21727 Page 1 and 2 should be filed within 72 hours after death with 16630 Annandale Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1. X Yes 2 \(\sum \) No Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Call Center Site Lead +2Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Betty Dixson Edward L. Stouter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 16630 Annandale Rd., Emmitsburg, MD 21727 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Kelley Stouter / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Frederick, Maryland 6/21/2011 Stauffer Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21, Signature of Funeral Service Licensee 104 East Main Street, Thurmont, MD 21788 OW to complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. Let Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Brain Cance M disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No certificate 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 🗌 Yes 2 No within 24 hours after deau.

To the Funeral Director: f Accident Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or invesus 3 Certifying Nurse Practioner: To the best of my knowledge, de (Check d at the time, date and place, and due to the cause(s) and manner as stated. ath occurr only one) 29b. Signature and title of ertifie 29d. Date signed (Month.

State Registrar 30. Name and address of pe

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31. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

ESKANder

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			1 - State of Maryland State of Maryland		artment of F rtificate of		_	giene Reg. No. 20	11 22361
	Dharaisi		Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	3. Time of Death
	Physici /Medic		Maryland Darlene Spies				June 24		
	Examin	er	4a. Facility Name (If not institution, give street and number) Mallard Bay Care Center			ridge		Dorche Dorche	
ı	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 XXF 7. Age (In yrs. Ia 57	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of Bir (Month, Date of May 29,	1954	9. Birthplace (State or Foreign Country) Mary Land
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
5	Mary Fied	tor	Maryland Dorchester	Cambri	idge				1. Yes 2 □ No
S	h the	irec	10e. Street and Number		10f. Zip Code			10g. Citizen of W	/hat Country?
7	23a c	rai	701 Race Street		21	613		US	
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give 1		Was Decedent of H If Yes, specify Cuba 1 □Yes XX No	lispanic Orig an, Mexican, Specify:	gin? (Specify Yes or No Puerto Rican, etc.)	Black	e - American Indian, k, White, etc. : White
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, Mar	and 2 sho salth and n 27 is m er traum		19a. Informant's Name/Relationship <i>(Type. Print)</i> Tanya Griffith Daughter				r or Rural Route Numb Trappe, Ma		
altimore, Maryland 21215-0036	Pages 1 nent of Ha nt: If Iten ry or oth		20a. Method of Disposition 1	ice of Dispo metery, cren Ley Ch	sition (Name of matory or other place nurch Cem	ce) (Date 5/28/2011		City or Town, State , Maryland
Balt	permit. Departit Importa any inju		21. Signature di Funeral Servico Licensee	Tf	Name and Address nomas Fun O Locust	ss of Facility eral I Stree	Home, P.A.	lge. Mary	yland 21613
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	vithir To th	Me	29b. Signature and title of certifier		29c. Licens				i (Month, Day, Year)
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	N		30. Name Ind address of person who completed cause of death (Item		Print)	am L	773 riage, M	0	
	Sta	to	Parkicia Johnson 100 Bi 31. Date filed (Month, Day, Year) 3. Registrar's Signan			OFFI O	rage, 101		
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Physici		Decedent's Name							2. Date of D Month		Year	3. Time of Death
viedicai Exam	iner	Dyrrian M. 4a. Facility Name (if			mher)		4h City Town	n, or Location of Dea	June 25	5, 2011	County of Deatr	1900 hrs
		Civista Hosp		, give on oot and no	mber)		LaPlata	, or Location of Bos	201		harles	''
Funeral		5. Social Security N	umber	6. Sex	7. Age (In yr	s. last birthday)	If Under 1			Birth (MM/C		rthplace (State or
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5-0036 led within 72 hours afte Hygiene. other than "natural" the Medical Examine		17. Father's Name (First, Middle, L	ast)		<u> </u>		18.Mother's Nan	ne (First, Middle	e, Maiden S	Surname)	
21215-0036 wild be filed within 7 Mental Hygiene, marked other than	Be	William E		_					ica Mar			
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Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 Donation 5				•		July 5, st Church.		Nar	njemoy,	Maryland
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Physician // // // // // // // // // // // // //		23a. Part J. Enter the failure. List only	e disease, or o y one cause o	omplications that can n each line.	used the dea	ath. Do not enter t	he mode of dy	ing, such as cardiac	or respiratory	arrest, shoc	k, or heart	Approximate Interval Between Onset and
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30x 6876 leath certificate e attending phy for use as the b	icia	past 12 months?		4 Pregna	ant at time of		her (Specify)			"		, , ,
Bo he dea	Physician/N	1 Yes 2 N	, 🗀	9Unkno					Loo o:			
i, P.O.	by	Part II. Other signifi	cant conditio	ns contributing to	death but no	t resulting in the u	inderlying caus	se given in Part I.				the cause of death?
ords, wequires is been signatured be	ompleted								24a. Wa			topsy findings available
Records, The law require ficate has been si	n p						<u>. </u>		aut	opsy formed?		ompletion of cause of
tal Rectian: The l	O,	25. Was case referre	d to modical				26 Di	and of Dooth (Ohea)	1 ✓ Yes	2 No	1 Ye	s 2 No
Vital bysician this cert	o Be	examiner?		Hospital: 1	patient 2	✓ ER/Outpatient		Other Nurs	ing Home 5	Residence	ce 6 Other:	
ing Phy After th		1 ✓ Yes 2 27. Manner of Death	No	28a. Date of	of Injury	28b. Time of I		njury at Work?	28d. Describ	e how injury	y occurred	
ion tendir eath. for: A	atior	1 Natural 2 ✓ Accident	5 Pendin			FOUND: 1819 hrs	1	Yes 2 V No	child drow	ned in po	ool	
or At or At after d Direct	ertification:	3 Suicide	6 Could	28e. Place		home, farm, stree	et, factory, offic	e building, etc.	28f. Location or Town		d Number or Rur	ral Route Number, City
Div spital or hours afte neral Dir filled in	Ser	4 Homicide	determ	(Opeciny)	Swimmin				7100 Benns	ville Road	d , Waldorf , M	
Division of Vital Records, P.O. Box 68760, To the Etopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	(Check only		sician: To the best iner:On the basis o	f examination							
1	₹ Z	29b. Signature and ti	tle of certifier	and manner sta	ated.	2	29c. Lice	ense number		29d. Da	ate signed (Mon	oth, Day, Year)
		61.	1.1	M	X	~	0.6	C.M.E.		June	26, 2011	
707	ŀ	30. Name and address			,	,						
202		Zabiullah Ali,		ssistant Medica	*		altimore St	treet, Baltimore	, MD 21223	3		
St Regist	ate rar	31. Date filed (Month	IN 28 2	2011 32 Reg	gistrar's Signa	J. John	Kant					
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Division of Vital Records, P.O. Dox 06/00
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and

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		For State Registrar		State	OT IVI	aryıanı		rtificat				Mental I		ene. g. No.	20		223	363
Physicia	ın/	1. Decedent's Name		e, Last)	Ha							2. Date o	f Death	Day		Year	3. Time of	
Medic Examin	al	4a. Facility Name (if				•		4b. City	Town, or	r Location	n of Death	June	: 2	24	20°	11_	4:45	P _M
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Funeral Director		5. Social Security No. 218 56 8		6. Sex 1 🔯 M 2 ☐ F	7. Age	e (In yrs. Ia 59	st birthday) Yrs.	If Unde Months	Days	If Unde Hours	Min.	8. Date o	f Birth , Day, Yo	ear) 52		9. Birth Cour	place (State or otry) MD	Foreign
nd how at	ř	Usual Residence of 10a. State	Decedent 10b. County	,		10c. City	, Town or L	ocation								Т	10d. Inside Cit	y Limits
Maryla 28a-f s otified	Director	MD	St.	Mary's		G	Great	Mil	ls								1 🔀 Yes	2 🗆 No
th with the Maryland ms 23a or 28a-f show must be notified at	eral Di	10e. Street and Nun 22025 E		ane					p Code					g. Citiz	en of Wh	nat Cou	ntry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 🛣 Never Marri 3 🗆 Widowed		If You G	orces?		. 13.	Was Dece If Yes, spe				ecify Yes or Rican, etc.)	No-			, White,		
72 hour an "natur Medical	Completed	(Spe	cify only high	ent's Education est grade completed	a()		(Give	edent's Usu kind of wo	ork done c		ost of work	ding	110	6b. Kin	d of Bus	iness In	dustry	
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hould and Me s marl umati		19a. Informant's Na		•	•		19b. Mail	ing Addres	s (Street a			al Route Nu			own, Sta	ite, Zip	Code)	
and 2 s fealth a fm 27 i			·	Brother						dson	Dr.	Lexi						553
Page 1 nent of int; If ii iry or o		20a. Method of Disp 1 ∰ Burial 2 4 ☐ Donation	☐ Cremation	3 ☐ Removal from	n State	Ce	ace of Disp emetery, cre :hesd	matory or	other plac			Date / 2011	- 1				own, State	
permit. Departn Imports any inju		21. Signature of Fur	neral Service I	CINU C	De j	TON	2	2. Name a	nd Addres	ss of Faci							ral Ho	
		23a. Part 1. Enter to	he dis, or rt failure. List o	r complications that	ach line		. Do not en	ter the mod	de of dying	g, such a	s cardiac				1401		Approximate Interval Bety	•
Physician/ Medical		Immediate Cause (disease or condition resulting in death)	Final	a	1-)	cle V	10 CC	3rci	nor	na	8/	Lur	195			_	Onset and D	
Examiner		Geograpially list on	n difference	Due to	(Or as a	FC		se '	to	th	sive	<u>.</u>	7					
ed sit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or	nmediate rlying	Due to	(or as a	consequ	ence of):											
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To the Hospital or Attending Physician: The law requires that the death certificate be aw within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		Birth gnant at		death 3	Ectopic Other (s		y				2	3d. Date Mont		- /	ear
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r Attencter death	Certificate:	2 Accident 3 Suicide 4 Homicide	investi 6	not be 28e. Place		ry - At hor . (Specify)	ne, farm, st	M reet, factor		Yes 2	_l No		on (Stree		Number	or Rura	l Route Numbe	e <i>r</i> ;
ospital o hours af ineral Di d filled in	Medical C	29a. Certifier 1	Certifying	Physician: To the	pest of	my knowle	dge, death	occured at	t the time,	date and	d place, ar	nd due to the	e cause	(s) and	manner	as state	ed.	
the Ho thin 24 the Fu	Med	(Check 2 only one) 3	☐ Medical E	Nurse Practioner	sis of ex	camination	and/or inves	stigation, in death occu	my opinio urred at the	on, death on e time, da	occurred a	t the time, da	ate and p to the ca	place, a ause(s)	and due t and mani	o the ca ner as si	use(s) and mar tated.	ner stated.
5 ≥ 6 00		29b. Signature and t	title of certifier	frish	n			29	c. License	711	199		290	O.C	signed (b	Day, Year)	
B/41		30. Name and addre	vent	who completed cau	se of de	eath (Item	23a) (Type,	Print)	ites	ali	ny	Drin	4, 1	Ani	nay	noc	3, MI) ,
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Harris Struven 2011 22364 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Examiner 0705 hrs William Harris Struven June 25, 2011 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death 7547 Libertytown Road Worcester 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. Director 214-84-4371 49 6/1/1962 Country) 1X M 2 F Yrs MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 8how 1 Yes 2 X No Worcester Berlin Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10e Street and Number 10f, Zip Code 10g. Citizen of What Country 7509 Libertytown Rd. 21811 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Contractor Extermination 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles M. Struven Virginia Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 1 1303 Points Reach, Berlin, MD 21811 Virginia Lewis / mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State irst State Crem. 6/27/11 Millsboro, DE 4 Donation 5 Other Specify 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Ser 108 William St., Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Intra-oral Shotgun Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Dav Fetal death Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this centific completely filled in by the funeral director, 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) B examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work Subject shot self 1 Natural FOUND: 5 Pending 1 Yes 2 ✔ No Jun 25, 2011 0630 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 7547 Libertytown Road, Berlin, MD determined (Specify) Field Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 26, 2011 30. Name and address of person who completed cause of death (Item 23a)

BA 5+1

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Registrar's Signature arke

State

Registra

31, Date filed (Month, Day, Year)

7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22365 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 11, Day 2011 Year 3:54 p Tawney Betty Spencer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🔀 F Months Days Apr 14, Year 928 Hours Director Yrs 83 MD 212-24-6162 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Carroll Westminster 10e. Street and Number ò 10f. Zip Code 10q. Citizen of What Country? Funeral 23a 304 Beacon Mews Ct items 2 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 NO Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", Completed 3 X Widowed 4 ☐ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and 2 should be filed within 72 Health and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward F. Tawney Ethel Smith injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 75 South Gala Littlestown, PA 17340 Edward W. Spencer/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Leisters Cemetery 6/15/2011 Westminster, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21157 412 Washington Rd. Westminster, MD 23a. Phr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ed by the a 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ₽ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s certificate 2 No 1 Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ٩ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence OSpice this funeral 27. Manner of Death n 24 hours after death.

Pe Funeral Director: After the oleted filled in by the funeral 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the h within 2 To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) WIL 8 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who SIKOrski

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22366 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Donald Burnett Sharpe 20 7:10 a M June Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Year) 9<u>27</u> 1 X M 2 □ F Months Days Hours Min. 83 017-20-7920 Massachusetts **Director** Usual Residence of Decedent show. 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Carroll Westminster 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 Plankwood Road 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Government Defense Design Engineer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o William A. Sharpe Etta Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane E. Sharpe, wife 410 Plankwood Road, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Important; If injury or 6/23/2011 Silver Run, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home any Willis Street, Westminster, MD 21157 Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Melanoma Metastorn Physician/ disease or condition 41 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertains Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital Other: 2 TN0 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 52_035 29b. Signature and th e of certifie 29d. Date signed (Month, Day, Year, ello 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminste

Registrar DHMH 17 Rev 7/2009 CH

31. Date filed (Month, Day, Year)

291 Stone

Registrar's Signature

21157

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Reg. N2	0	1	2	2	3	6
VICIILL	rrygiciic						_

Physician/	
Medical	
Examiner	

Joseph Schauer 2. Date of Death June 22, Day 2011 Year

3. Time of Death 11:00 P M

Funeral

Director

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

er	4a. Facility Name (if		4b. City, Town, or Location of Death					4c. County of Death					
	Casey H						ville				lontgo		<u> </u>
	5. Social Security No. 214-52-4		Sex 7. Ag	e (In yrs. last birti 64	hday) Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of Bir 03 19 19		,		thplace (State or Foreign Shington, DC
	Usual Residence of			04	113.				03/19/.	174	<i>'</i>	was	sitting coil, DC
ē	10a. State	10b. County		10c. City, Town	or Loca	ation							10d. Inside City Limits
<u></u>	Maryland	Prince	e George's	Ft.	Was	ashington							1 🗆 Yes 2 🔀 No
<u>=</u>	10e. Street and Nun	nber				10f. Zip Code				10g.	Citizen of V	Vhat Co	untry?
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Completed by Funeral Director	11. Marital Status		12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	lispanic Ori an, Mexica	igin? (Spe	cify Yes or No- Rican, etc.)			e - Ame k, White	rican Indian,
d b	1 ☐ Never Marri 3 ☐ Widowed		If Yes, Give	No		☐ Yes 2 😾 χ No			. ,		Specify:		_
ete	3 🗆 Widowed	15. Decedent's	Year or Dates.	162		ent's Usual Occup				4.01			ite
ם	(Spe Elementary/Seco	cify only highest	grade completed)		(Give ki	nd of work done NOT use retired)	during mos	st of worki	ng	100.	Kind of Bu	ISITIESS	Industry
ပိ	12th	onday (U-12)	College (1-4 or 5) N		anic					ľ	Mach	ninery
Be	17. Father's Name (I	First, Middle, Las	t)				18. Moth	er's Name	e (First, Middle,	Maide	n Surname)	
은	Robert	George	e Schauer				I	Louis	e Anı	1	Baber	r	
	19a. Informant's Na				Mailing	Address (Street	and Numb	er or Rura	l Route Numbe	r, City	or Town, Si	tate, Zip	Code)
			uer / Broth	C1		Peed Rd	., DI	and y	wille, r	ע ע	0013		
	20a. Method of Disp 1 Burial 3x	Cremation 3	☐ Removal from State	cemeter	y, crema	tion (Name of story or other pla	ce)	_	Date				Town, State
	4 Donation	5 Other (Spe	ecify)	Kalas		matory	- 1		/2011				Maryland
	21. Signature of Fur	neral Service Lige	ensee		6	Name and Addre $160~0{ m xor}$	ss of Facili Hill	^{ty} Geo L Rd.	rge P. Oxon H	Ka: lil	las Fu L, Mai	uner ryla	al Home PA and 20745
	23a. Pad . Enter the shock, or hear	he disease, or co t failure. List only	mplications that caused one cause on each line	d the death. Do n									Approximate Interval Between
	Immediate Cause (disease or conditio				L	IVER CA	NCER						Onset and Death
	resulting in death)	-	Due to (or as	a consequence o	of):								
ř	Sequentially list con	nditions,	b										
nin	if any, leading to im cause. Enter Under	lying 🔣	Due to (or as a	a consequence o	of):								
Exai	Cause (Disease or i that initiated events resulting in death) L	3 1	c. Due to (or as	a consequence o	of):							-	
Physician/Medical Examiner			d										
Mec	IF FEMALE:	1											
ian/	23b. Was decedent in the past 12 r		23c. If yes, outcome 1 Live Birth	of pregnancy 2 Fetal death	3 🗆	Ectopic pregnand	су				23d. Dat		,
/sic	1 Yes 2 S		4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 🗌	Other (specify) _					Mor	nth	Day Year
		icant conditions	contributing to death b	ut not resulting in	n the un	derlying cause gi	ven in Part	I.	23e Did t	obacco	Luse contri	hute to	the cause of death?
d by						,							robably 4 🗆 Unknown
ete													
mp									24a, Was auto	OSV	р		opsy findings available completion of cause of
Be Completed by	25. Was case referre	ed to medical				00 P		45 /Ob 1		2 2	No 1		2 🗆 No
To B	examiner?] No	Hospital:	ent 2 ER/Ou	tootiont	Oth	ace of Dea				a fi tro		Uognico
e: T	27. Manner of Death	_	28a. Date of inju	ry 28b. T	ime of	28c. Injur	v at	2	me 5 Resi				fy) Hospice
ical	1 XX Natural 2 ☐ Accident	5 Pending Investigat		, rear) Ir	njury	M 1 🗆	Yes 2	No					
ertii	3 ☐ Suicide 4 ☐ Homicide	6 U Could not determine			m, stree	t, factory, office	•	2	28f. Location (\$ City or Tow			r or Rur	al Route Number,
al C				. (oposity)					City of You	m, Sta	.e)		
Medical Certificate:	29a. Certifier 1 (Check 2 only one) 3		nysician: To the best of miner: On the basis of ex urse Practioner: To the	xamination and/or	r investig	ation, in my opinie	on, death or	ccurred at	the time, date a	ind plac	ce, and due	to the o	ause(s) and manner stated
	29b. Signature and t		7.			29c. License		- p					, Day, Year)
	1 / 1/9,	Wah.	mela	in CR	NP	21432	201			4	/23	/1/	
	30. Name and addre Debor	ess of person who	o completed cause of de ler CRNP	eath (Item 23a) (T 6001 Mi	Type, Pri UNCA	ster Mil	L1 Rd	. Roc	kville	, M	I D	, .	
e ar	31. Date filed (Month	JUN 2 4	2011 32. Registra	ar's Signature	b	ake		·					

State Registrar

11-04946 Kate Sweely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg	ible.	
State of Maryland / Department of Health and Mental Hygiene	2011	22

(ate Sweely		Sta 1- For State Registrar	te of Maryla	nd / Dep	artment of	Health a			giene		11	22368
Physici		1. Decedent's Name (First, Middle	,Last)						2. Date of Dea Month		ar.	3. Time of Death
Medical Exam	iner	Kate Sweely 4a. Fecility Name (if not institution,	Table Street Santan			41- O'L T			July 2, 20	11		1324 hrs
		Johns Hopkins Hospita	l			4b. City, Town, Baltimore		Death		4c. County		
Funeral Director			5. Sex	7. Age (In yrs. 20			ear If Under ays Hours	24Hrs. Min.	8. Date of Bir	th(MM/DD/YYY) /1991		hplace (State or n Maryland
		Usual Residence of Decedent	1 W 2 F		Yrs						000	andy, J
ith the Maryland 23a or 28a-f show any notified at once.	ctor	Maryland Anne A	rundel		napolis	on 10f. Zip Code			11	0g. Citizen of WI	nat Cour	10d. Inside City Limits 1 Yes 2 X No
the Ma a or 23	Director	1190 Ramblewood	Drive				409			United		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 A Never Married 2 Mar 3 Widowed 4 Divor		edent Ever in Urces?	If Y	s Decedent of I	an, Mexican, I	n? (Spe Puerto R	cify Yes or No tican, etc.)		e, etc.	can Indian, Black,
ours afi atural	d by	15. Decedent's Education (Specif	or Dates:	e completed)	16a. Deceden	t's Usual Occup	ation (Give ki	nd of wo	ork done	16b. Kind of Bu		
2 3 🗐	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)	Inte	ost of working li	te. DO NOT u	se retire	d)	Coddond	Sne	ace Center
5-00; ed with lygiene other t	Com	17. Father's Name (First, Middle, L	1		I Ince		18.Mother's	Name (First, Middle, M	Maiden Surname	-	ice center
21 be fil brital briked vent,	Be	Doug Sweely					Lori					
MD 2 d 2 shoul lth and M n 27 is m	To	19a. Informant's Name/Relationship Doug Sweely/Fath								ober, City or Tow		
re, N. 1 and 1 Health		20a. Method of Disposition 1 Burial 2 X Cremation		20b.	Place of Disposi crematory or oth	tion (Name of			Date	20c. Location -		
Baltimore permit. Pages 1 a Department of He Important: If it	Ш	4 Donation 5 Other Spec	cify:		las Cre	natory						Maryland
Baltimore, MD 2' permit. Pages 1 and 2 should Department of Health and MI Important: If Item 27 is ma injury or other traumatic e		21. Signat of Fun ral S	7							Kalas Fu		
Physician		23. Part I. Enter the disease, or confailure List only one cause or	omplications that ca	used the death	n. Do not enter th	e mode of dyin	g, such as car	diac or r	espiratory arre	,_Edgewa est, shock, or hea	er,	MD 21037 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a_Complic			ıdotumo	r Cerel	bri				Death Death
		Sequentially list conditions,	Due to (or as a ob.	consequence o	м):							
	mine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence o	of):							
red nsit	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):							
e executed cian and rial - trans	dical	X UNPENDED	AMENDED 2	3a,27,	per me,g	918 8-3	30-11 s	m				
8760 ificate l ig physi s the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, or	utcome of preg		al death 3	Ectopic p	regnand	*V	23d. Date of Month	delivery Da	ay Year
Box 68760, death certificate be executed the attending physician and dfor use as the burial - transi	Physician/Me	past 12 months? 1 Yes 2 № No 9 Unknown	4 Pregna	nt at time of de	ath =	er (Specify)		regriain		Month	Uz	ay real
O. B. at the de d by the trached f		Part II. Other significant condition			esulting in the ur	nderlying cause	given in Part	l.	23e. Did tol	bacco use contri	oute to th	ne cause of death?
S, P.O uires that the n signed by ld be detac	ed by											ably 4 Unknown
Vital Record yaician: The law req his certificate has bee director, page 2 shoul	Completed							_	24a. Was a autops	sy p		opsy findings available impletion of cause of
tal Reco		25. Was case referred to medical	<u> </u>			20.51	(8-4) (0		1 ✓ Yes 2		✓ Yes	2 No
Vital hysician this cert	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 🗸 In	patient 2	ER/Outpatient		Other4		Home 5 F	Residence 6	Other:	
Division of Vital Records, talor Attending Physician: The law requir rs after death. "I Director: After this certificate has been sited in by the funeral director, page 2 should the fine of the funeral director.	-1	27. Manner of Death	28a. Date o (Month, I	f Injury Day, Year)	28b. Time of In		ury at Work?		3d. Describe h	ow injury occurre		
Attend Attend or death rector: by the	icatic	2 Accident Investig	gation 28e Place	of Injury - At he	ome, farm, street		Yes 2 N		of Location (S	troot and Number	a a a Dura	al Route Number, City
Div	Certification:	3 Suicide 6 Could r 4 Homicide determi	lot be	o,	orne, rann, orreer	, lactory, office	bulluling, etc.		or Town, St		i oi Ruiz	in Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	edical	one) 2 Medical Examin	sician: To the best ner:On the basis of and manner sta	examination a	ge, death occurr nd/or investigation	ed at the time, o	date and place	e, and du	e to the cause ne time, date a	e(s) and manner and place, and du	as stated	i. cause(s)
F 7 F 3	Σ	29b. Signature and title of certifier	1/40	111	4000		se number			29d. Date signe		h, Day, Year)
		30. Name and address of person wh	no completed cause	of death (Item	23a)	0.0	.M.E. 			July 4, 2011		
A+3		Victor Weedn MD JD	Assistant Med			Baltimore	Street, Balt	timore	, MD 2122	3		
St Regist		31. Date filed (Month, Day, Year)	7 2011 32. Reg	grar's Signatu	B. A	ares						
		775			1-17							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 22369 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month Luella Stridicon 7:40P JUNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 24 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Year 1930 Months Days Hours 213-36-8614 Director Yrs Virgin Island 81 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4911 Frederick Ave 21229 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 XDivorced **Black** Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 11th 0 Librian Baltimore City other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl Anduze Josephine Graham 1 and 2 should be of Health and Mer fitem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08824 Lois Stridiron Harris(Daughter) 3424 State Rt. 27 #58 Kendall, N.J. 20a. Method of Disposition 20b Be Sot Bestien (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o Important: If if any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 6 - 27 - 11Annapolis, Md. Williame Reactions Security, 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. Tree 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Lung Cuncer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No or Month Dav Year 1 Yes 2 g Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ω. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed Yes 2 No certificate 2 No 1 Yes or Attending Physician: the Funeral Director: After this certific repleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 Yes 2 No death. ☐ Accident ☐ Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after within 24 hours a To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRW apameM.O 6/18/11 20057465

State Registrar 31. Date filed (Month, Day, Year) **JUN 2 7 2011**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S.RajaPIKSe, MID

32. Registrar's Signature

2835 Smith AV

Baltimore MO 21209

			1 - State Registrar Ce	eartment of Health and Mer	ntal Hygiene Reg. No 2011	22370
-1	Physicia Medic	cal	1. Decedent's Name (First, Middle, Last) William L. Selle		Date of Death Month 25 20 11	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Takoma Park If Under 1 Year If Under 24 Hrs. 8	4c. County of Dea Montgome Date of Birth 9. Bi	ery
	Funeral Director		5. Social Security Number 6. Sex 1.4 M 2 TF 7. Age (In yrs. last birthday) 85 Yrs. Usual Residence of Decedent			rthplace (State or Foreign ountry) NC
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral Director	MD Prince Georges Hyattsvil	<u>le</u>		10d. Inside City Limits 1 Å Yes 2 □ No
	with th 23a o ist be	eral I	5800 35th Place	10f. Zip Code 20782	10g. Citizen of What C	-
	leath v items er mu	Fune	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica		
9003	1 and 2 should be filed within 72 hours after dea if Health and Mental Hygiene. Item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner	þ	3X Widowed 4 □ Divorced 1 No Yes 2 □ No If Yes, Give Year or Dates. 1945	1 ☐ Yes 2 X No Specify:	Diagni, villa	te, etc. White
1215-	within 72 ho giene. er than "na er the Medic.	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation kind of work done during most of working OO NOT use retired) Layer	16b. Kind of Business Federal	s Industry
Maryland 21215-0036	l be filed w lental Hygi rked othe tic event, i	To Be	17. Father's Name (First, Middle, Last) Charles A. Selle		rst, Middle, Maiden Surname)	
	nd 2 should lealth and M m 27 is mar her traumat			ing Address (Street and Number or Rural Ro Vemb1y Way Severna P	ute Number, City or Town, State, Z	ip Code)
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or oth	9 4	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposerery, cre		20c. Location - City of	
Balti	permit. Page · Department o Important: If any injury or once.		21. Signature of Juneral Service Licensee 2	2. Name and Address of Facility Ft. I 401 Bladensburg Rd.	incoln Funeral	Home
44	Physician/ / Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the wath. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		piratory arrest,	Approximate Interval Between Onset and Death
	ite be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any loading to immodrate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. SPSIS Due to (or as a consequence or): CORONO O Due to (or as a consequence or):	nten desease		
092	icate be e g physicia is the bur	ledical I	d			
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)	23d. Date of de Month	elivery Day Year
ds, P.O.	requires that the de been signed by the should be detached	2	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did tobacco use contribute to	
Records,	The law re cate has be page 2 sh	Completed			autopsy prior to performed? death?	utopsy findings available completion of cause of
ita	ician: The certificate rector, pag	m	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only	one)	
n of Vital	nding Physician: T th. : After this certifics ? funeral director, p	cate: To	1	nt 3 □ DOA	5 Residence 6 Other (Special Describe how injury occurred	cify)
Division	al or Atter s after dea I Director d in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. i	Location (Street and Number or Ru City or Town, State)	ıral Route Number,
_	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investorily one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at the t	ime, date and place, and due to the	cause(s) and manner stated.
ø	To the within 2 To the comple					
R	-6		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, I STEVENT, TEE MD 3415 H M 31. Date filed (Month, Day, Year) JUN 3 0 2011 A. A. A. A. A. A. A. A. A. A. A. A. A.	nilton st hyafl	bulle Mb Z	0782
	Stat Registra	e ir	JUN 3 0 2011 32. Registrer's Signature			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Louise F. Stroman Jun Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 90 Yrs Clinton N.C. Director 241-24-1394 Usual Residence of Decedent 28a-f show 뒮 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified 1 X Yes 2 No Md. Upper Marlboro P.G. 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2817 Coronella Court 20774 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) Health and Mental Hygiene. 6th <u>Maintenance Worker</u> U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ (Unknown) Sparrow Emma Faison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane C. Budd/Daughter 2817 Coronella Court, Upper Marlboro, Md. 20774 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. 07/08/11 Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. aule 4925 Burroughs Ave., N.E., Washington, D 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ PERNOTREM, A disease or condition resulting in death) Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician: The law requires that the death certificate be executed BMENTIA and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) for (in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death 1 Yes 2 g the 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?] Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 2 funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Propatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 06/24/1 MDD58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 101A, Greenbeit, MD. 20770

Registrar

7500 Hanover Parkway

MD

31. Date filed (Month, Day, Year)
JUN 3 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Thomas -39M Robert Stitcher JUNE 2011 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Poninsula Regional Medical Micomico 8. Date of Birth If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Min. (Month, Day, Year) 2-18-1946 Yrs Director 215-42-2605 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e, Street and Numbe 10f. Zip Code 10q. Citizen of What Country? Funeral 1301 Hazel Street 21804 USA death v 12. Was Decedent Ever in U.S. Armed Forces?

1 🔯 Yes 2 🗆 No 19 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or 2 1 Never Married 2 X Married within 72 hours after 1966 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Completed 3 Divorced Year or Dates 1968 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Route Salesman Bakery filed v Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked or ပ John Henry Stitcher Evelvn Bridgette Hockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Stitcher - Wife 1301 Hazel Street, Salisbury, Maryland 21804 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) rematory of Delmarva 6-23-2011 | Delmar, Delaware Signature of Funeral Service Licen 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List optione cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Cardiomyo Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury enal ha and-tran that initiated events resulting in death) Last Due to (or as a consequence of) the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No jo Month Day Pregnant at time of death the detached 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No this certificate To the Funeral Director: After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide Investigation

To the Hospital within 24 hours a To the Funeral C 110 State Registrar

DHMH 17 Rev 7/2009

Medical

6 Could not be

M.D

Das.

JUMN2X

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106 Milford ST. # 405 B

32 Registrar's Signatu

determined

4 Homicide

Babulal

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Gettiying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gettiying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D57952

Salisbury,

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

06/22/11

MD 21804

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald E. Sinrod $\mathbf{June}^{ ext{Month}}$ 2011 23:00 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🕱 M 2 🗆 March 28, **Director** 577-46-1455 Washington DC 75 1936 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland Director 10c. City, Town or Location 1 🎦 Yes 2 🗌 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6405 Rock Forest Drive Apt. 102 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5<u>+</u> Lawyer Law permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Sinrod Lillian Laskin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Sinrod Ferreri/Daughter 13530 Manor Road, Baldwin, Maryland 21023 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King David Mem. Grds. 6/26/2011 Falls Church, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facilianzansky-Goldberg Memorial Chapels Mcgheenhio MO1597 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final ⊸h, sician/ Acute Myocardial Infarction Innieudate disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Coronary Atherosclersis 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial- tagest Hypertension 20 Years attending physician and I for use as the burialthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hyperlipidemia 20 Years Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy ☐ Yes 2 🔀 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 10

Registrar

DHMH 17 Rev 7/2009

State

JUN 28

5550 Wisconsin fre +700 Cherychak ma 20817

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 26 per DVR G917 7/14/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Day 2011 Colleen F. Selsor June 19, 1:50 a м Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Westminster Golden Living Center Carroll 8. Date of Birth (Month, Day, Ye Dec 23, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1920 West Virginia 1 M 2 X 90 Months Days 165-14-6028 **Director** Vrs Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Westminster Maryland Carroll 1 🗌 Yes 2 🕱 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 835 Western Chapel Road USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white 3 X Widowed 4 ☐ Divorced Specify: Completed and Mental Hygiene.

is marked other than "natur
aumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Oil & Gas life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Distribution Owner Be Page 1 and 2 should be filed iment of Health and Mental Hy cant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dolle Heinzman ൧ Willard Ferrell traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 166 Glyndon Trace Dr, Reisterstown, MD 21136 Marilyn S. Urban, daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 1 Durial 2 Cremation 3 Removal from State Crents/tolograpry or other place) 4 ☐ Donation 5 ☐ Other (Specify) 6/21/2011 York, PA Direct Service Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home ton 91 Willis Street, Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury MEL ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year 9 I linknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 L 1 Yes 2 WO Division of Vital 25. Was case referred to modical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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			For State	of Maryland / De			lental Hygi	ene	22275
			Registrar 1. Decedent's Name (First, Middle, Last)		ertificate of De	eath		9. N2011	22375
I	Physicia			rner			2. Date of Death Month	Day Year	3. Time of Death
A.	Medi Examir		4a. Facility Name (if not institution, give street and n	umber)	4b. City, Town, or L	ocation of Death	June	4c. County of Deat	
	/		7611 Surratts Rd		Clinto	n		Prince (
	Funeral	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent	85 Yrs.			8-26-19	Nev	V York
	shov dat	후	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Mary 28a-1 otifie	Director	Maryland Prince Geor	ge Clinto	n				1 😾 Yes 2 🗌 No
	th the 3a or t be n	a B	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	ath wi	Funeral	7611 Surratts Rd 11. Marital Status 12. Was De	ecedent Ever in U.S. 13	20735			USA	
ယ္	er de or ite miner	by F	Armed	Forces?	. Was Decedent of Hisp If Yes, specify Cuban,			14. Race - Ame Black, White	
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lan	should and h is ma		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and				
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Jor	nt of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State 20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Di	ate 20	0c. Location - City or	Town, State
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee	Resurre	The second secon	7-1-2	2011 C	linton M	aryland
Ba	Departing Department of the suny in the su		Janes of Car	()	22. Name and Address of dams Fune	1	no Da A	anseco M	D 20608
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	t caused the death. Do not en	ter the mode of dying, s	such as cardiac or	respiratory arrest.	quasco H	Approximate
	Physician/	y i	Immediate Cause (Final disease or condition	reast cancer					Interval Between Onset and Death
	Medical Examiner		reculting in death)	o (or as a consequence of):					
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P.O. Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/M	1 Yes 2 No 4 Pre 9 Unknown 9 Unknown		Other (specify)			Widital	Day Teal
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Division of Vital Records,	or Atte frer de irecto n by ti	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Plac	e of Injury - At home, farm, sti	reet, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Rura	al Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the base only one) 3 Certifying Nurse Practioner	asis of examination and/or inves	stigation, in my opinion, o	leath occurred at th	o time date and a	lace and due to the o	augo(a) and manner stated
	Vithir Comp		29b. Signature and title of certifief)	To the best of my knowledge,	29c. License nu	mber		. Date signed (Month,	
			> MisRujapalnum.D		DOUS	7465	(0/24/11	
			30. Name and address of person who completed cau N.S. Rayapa K.E., M.D.	ise of death (Item 23a) (Type, I	Print)	3 2	ult mor	e MO	21209
	Stat			Begistrar's Signature	1. 01	5 0			
	Registra	_	JUN 28 2011	Registrar's Signature	PARA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22376 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month evai 0 301 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Social Security Number 07 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Country) Virginia 90 Director Yrs. 03/09/1921 230-09-1757 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Prince Georges Oxon Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 South Lawn Drive 20745 USA filed within 72 hours after death v al Hygiene. Jother than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Machines Typewriter Repairman Page 1 and 2 should be filed wit nent of Health and Mental Hygie ant: If item 27 is marked other i æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Edward Tevault Mary Ann Feltner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Thelma Tevault/Wife 7101 South Lawn Dr., Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5 cemetery, crematory or other place permit. Page Department of Important: If any injury or once, 06/29/2011 Winchester, VA Hebron Cemetery 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. 21. Signature of Funeral Service Licer MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Pnysician/ 9 disease or condition resulting in death) Medical Examiner Secrientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami and-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23b. Was decedent pregrant in the post 10 ALU 23c. If yes, outcome of pregnancy Physician/ 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month the detached 9 Unknown P.0. ģ been signed be should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death?
1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Unursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month Day, 410 1 Natural AIC 5 Pending 1 🗌 Yes 2 🗌 No NIA Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

RBS+|

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ James Richard Travis 26, 2011 6:55 pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 \square F Indiana Days Hours 65 Yrs 08/25/1945 471-50-4125 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number ms 23a or must be r ō 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygient. Important; If fear 17 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 20904 u.s.A. 13008 Peaceful Terrace 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 2 No 1967-Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify Completed 3 Widowed 4 Divorced 1971 Specify. Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) IT Information Management æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Mary Louise VandeVanter James Leonard Travis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 13008 Peaceful Ter., Silver Spring, Maryland 20904 Francoise Catherine Traviš 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 06/27/2011 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Esophageal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin, Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 X Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 🛣 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's 2 🗶 No Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 € Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural work' ☐ Accident ☐ Suicide Investigation 1 Tes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Debrah Miller, CRNP,

JUN 28 2011

1. Date filed (Month, Day, Year)

R143201

6001 Muncaster Mill Road, Rockville, Maryland 20855

		For State Registrar 1. Decedent's Name (First, Middle, Las	State of Ma		/ Depa		Health an	d Mental Hy	/gienę Reg. N	วิกเเ	22378
Physicia Medic Examin	al	Frank Morris van de Facility Name (if not institution, give	ler Linden			4b. City, Town, c	r Location of D		23, Da	2011 County of Death	3. Time of Death 5:25 A
Funeral Director		243-01-3584		(In yrs. last	birthday)	If Under 1 Year Months Days				9. Birtl	omery hplace (State or Foreigi intry) N . C
ie Maryland ir 28a-f show notified at	Director	Usual Residence of Decedent	omery	10c. City, 7	Town or Loc	Beth	esda		40.0		10d. Inside City Limits
r death with the or items 23a coniner must be	y Funeral Director	5301 Westbard Cir 11. Marital Status 1 □ Never Married 2 🛛 Married	cle #247 12. Was Decedent Every Armed Forces? 1 yes 2	er in U.S.	13. V		20816 ispanic Origin? an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)		USA 14. Race - Amer Black, White	ican Indian,
72 hours afte In "natural", (Medical Exan	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grade)	If Yes, Give Year or Dates. lucation de completed)		16a. Deced	ent's Usual Occupind of work done of NOT use retired)	ation	working	16b. K	Specify:	White ndustry
be filed within ental Hygiene. ked other tha c event, the I	To Be Col	17. Father's Name (First, Middle, Last)	College (1-4 or 5+			Journa	alist 18. Mother's	Name (First, Middle	, Maiden		e Press Corp
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		William H. van 19a. Informant's Name/Relationship (Ty Frank R. van der 20a. Method of Disposition	pe, Print)	n .	5850		and Number or	ida Morr Rural Route Numb Washingto	er, City or	C 20015	
permit. Page 1 Department of Important: If it any injury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licens)	cem	netery, crem nlawn 22.	Cemetery Name and Addre	ss of Facility	Date /25/2011	Wil	ocation - City or 1 1 1 1 1 1 1 1 1 1 1 1 1	t, MD
Physician/ Medical Examiner		23a Part 1. Enter the disease, or conks shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused to cause on each line.	bra1	Do not ente	r the mode of dyir		eral Direcke Rockvi		MD 2085	Approximate Interval Between Onset and Death
be executed sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.	77							
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the the page 2 should be detached for use as the the page 2 should be detached for use as the the page 2 should be detached for use as the the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use 3 shou	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal d	eath 3 🗌	Ectopic pregnand Other (specify)	şy			23d. Date of deli Month	very Day Year
equires that t	ted by P	Part II. Other significant conditions co		t not resulti	ng in the ur	nderlying cause gi	ven in Part I.				the cause of death?
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ending Physicia ath. rr. After this cert ne funeral direct	Certificate: To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	lospital: 1 ☐ Inpatier 28a. Date of injury (Month, Day,	28	/Outpatient b. Time of injury	3 DOA Other	er: 4 Nursin				Mospice
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Stat		30. Name and address of person who control Debrah Miller CRNS 31. Date filed (Month, Day, Year)		nth (Item 23	a)(Type,Pr er Mi	int)		e, MD 208	855	111	
Registra	r	JUN 2 7 2011	centra	p	7						

State Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For State Registrar	State of Maryland		rtment of F ificate of D		ivientai Hy	Reg. No	2011	22379
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2, Date of De Month	Day	Year	3. Time of Death
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	Examin	er	Mandrin Hospice	,	ľ	4b. City, Town, or Harwo	_	1		County of Death	undel
_	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
П	Director		219-29-4541 11	^{2 □} F 55	Yrs.	Months Days	Hours Min.	Dec 1	8 ^{ea} /19	55 E1"	Salvador
	show show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loca	ation				1	10d. Inside City Limits
	Maryla 28a-f	rect	Maryland Anne Aru	ndel Ann	apol:	is					1 ☐ Yes 2 ሺ No
	h the kaor 2 beno	al Di	10e. Street and Number	· ·		10f. Zip Code			10g. Citiz	en of What Cour	ntry?
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0	er dea or ite niner			Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No	lf `	Yes, specify Cuba	Decedent of Hispanic Origin? (Specify Yes or Nos, specify Cuban, Mexican, Puerto Rican, etc.)			 Race - Americ Black, White, 	
ğ	ırs aft ural", il Exal	ted t	0 - William 1 4 - B	If Yes, Give Year or Dates.	1 1	¥ Yes 2 □ No	Specify: E1	Salvad	orañ	pecify: Wh	ite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland and Hyglene. Red other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	Take the property of the prope								d of Business In	dustry
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ă ⊠	2 sh h an 7 is trau		19a. Informant's Name/Relationship (Type, H		_	Address (Street a					
ē,	Hear Hear	- 3	Augustina Ventur 20a. Method of Disposition			Bay Ri		P Anna		sation - City or To	
Ë			1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State Memo	rial	Holy के Miner place Garden	s 6-2	27-11	Ann	apolis	, Md.
Baltimore,	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Service Licensee		2W1	Marne al Reces	ef F&iiitySor	s Mort	uary	, P.A.	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									, Md.	
	N		shock, or heart failure. List only one ca	use on each line.	o not enter	the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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09/89	tificate ng phy as the		IF FEMALE:								
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Ť	: The I							1 🗆 Yes	2 No	death?	2 🗆 No
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0	g Phy er this neral d		27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/ 28a. Date of injury (Month, Day, Year) 28b	outpatient o. Time of injury	28c. Injury	at	ome 5 Residence 128d. Describe 1			110036
0	tendin eath. or: Aff the fur	ifica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(World)	прогу	M 1 🗆	Yes 2 □ No				
Division of	or Att	Certificate:	4 Homicide determined	8e. Place of Injury - At home, building, etc. (Specify)	farm, stree	t, factory, office		28f. Location (5 City or Tox		Number or Rural	l Route Number,
2	spital spital neral I		29a. Certifier 1 Certifying Physician	: To the best of my knowledge	e, death oc	cured at the time,	date and place, a	nd due to the ca	use(s) and	manner as state	ed.
	To the Hospital or Attending Physician: The law within 24 Juous after death. To the Funeral Director-After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2 Medical Examiner:	On the basis of examination and actioner: To the best of my kno	d/or investig	ation, in my opinio	n, death occurred	at the time, date a	and place, a	and due to the ca	use(s) and manner stated.
	Voith Com	_	29b. Signature and title of certifier	and Mi)	29c. License	number 3308	>		signed (Month,	Day, Year)
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1	#1		30. Name and address of person who comp	eted cause of death (Item 23a 1992) 2003 and 32. Registrar's Signature	e) (Type, Pri	cal Par	Kway !	310210	PT	2,	140
	<u> </u>	е	31. Date filed (Month, Day, Year) JUN 2 7 201	32. Registrar's Signature					_		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g917 7-13-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 22380 Reg. No. 2. Date of Death 23 1. Decedent's Name (First, Middle, Last) Physician/ Month 6 20^{Year}1 10:17PM Amelia Gordon Ward Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year_ If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 M 2 XF Days Hours (Month Day Year) 8 **Director** 219-38-4307 72 MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ocean Pines MD Worcester 10e. Street and Number 10g. Citizen of What Country? Funeral 40 Fort Sumter South 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2X No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 to Specify: Completed Specify: 3 Widowed 4 X Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Community Planner Rouse Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William H. Gordon Amelia Cheek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Young / friend 40 Fort Sumter South, Ocean Pines, MD 2181 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 NBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/2011 Owings Mills, Thomas Cem. MD Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate gauss. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NIDDM Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျင 1 X Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 🛛 Natural injury 5 Pending after death.

Director: Aft
d in by the fur Accident
Suicide 1 Yes 2 No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Curtifying Nurse Practices: To the Cause of the Cause (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H44828 6/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN 20 Brookellen Rider, D.O. 314 Franklin Ave., Berlin, MD 21811 31. Date filed (Month, Day, Year) State JUN 2 parke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANTHONY ELDRIDGE WHITTINGTON JULY 5,2011 16:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MD. HOSPITAL CLINTON P.G. CENTER 9. Birthplace (State or Foreign MD ountry) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours **1** M 2 □ F 2 Mgth, Pay 235 216-38-5834 86 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD. PRINCE GEORGES BRANDYWINE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12409 NORTH KEYS ROAD 20613 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No NAVY
If Yes, Give
Year or Dates. Black, White, etc. 5 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 XNo Specify: er than "natural", the Medical Exa 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) SAFEWAY FOOD STORES WAREHOUSEMAN 7th traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is many injury or other. ည RICHARD EDWARD WHITTINGTON IDA MAY WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE WHITTINGTON-SPOUSE 12409 NORTH KEYS RD. BRANDYWINE, MD. 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEM. 7-11-11 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) MQ.0479 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Acute disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit The law requires that the death certificate be executed Covonavy that initiated events Due to (or as a consequence resulting in death) Last Physician/Medical covonas Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) ____ IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed dislase Chrome Rid ney Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has autopsy perform death? 2 **X**N Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

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Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

Mai

31. Date filed (Month, Day,

1 3 2017

VUU

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Value G. Champaloux MD. Upper Manlboro.

Champaloux

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number 049

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 935 VIN Sune ena Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death alk at Age (In yrs. last birthday) If Unde If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day **Director** Usual Residence of Decedent items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No a 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 2 U 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ō þ 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates "natural" Completed 3 Divorced 4 Divorced ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry be filed within 72 permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Manany injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) 2 To Be 17. Father's Name (First, Middle, Last, arence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ore Annie JaV 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rappe emetery 22, Name and Address | Facility Henry Funeral Ho Sio Washington 21. Signature of Funeral Service Licenses Home, P. A. MD,21613 St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing death). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Physician/Medical lanho Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ج</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Thrombouto 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗌 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

of person who completed cause of death (Item 23a) (Type, Print

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31. Date filed (Month, Dav. Ye

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ather Woy		S1 - For State legistrar	ate of I	Marylar		artment o rtificate o			and	Menta			Reg. No	20		
Physician/ edical Examine	r	1. Decedent's Name (First, Midd Heather R. W	Э		h\		2. Date of Death Month June 17, 20 4b. City, Town, or Location of Death					Day 2011	Year		3. Time of Death 0556 hrs	
	1	4a. Facility Name (if not institution 28253 Three Notch R		et and num	ber)			echan			Deau			St. Mary		
Funeral Director							Foreign	nplace (State or n ntry) PA								
te Maryland or 28a-f show any fied at once.	Ī	Usual Residence of Decedent 10a. State								10g. C	itizen of Wh	at Coun	10d. Inside City Limits 1 X Yes 2 No			
ath with the items 23a ast be noti		120 Innisbrook Bend 29483 USA 11. Marital Status 1 Never Married 2 Married						, etc.	an Indian, Black,							
2 hours after "natural", "Examiner after by	<u> </u>	3 Widowed 4 Dir 15. Decedent's Education (Spe Elementary/Secondary (0-12)		ates:	completed)		ent's U most o	f workin	cupation g life. D					Specify: . Kind of Bus	siness/Ir	
5-0036 ed within 72 hours tygiene. other than "natu he Medical Exan	<u>.</u>	12 17. Father's Name (First, Middle	Last)			Finan	cial	Ana	•	.Mother's	Name (F	First, Middle		efense		ractor
215- be filed antal Hy rrked of ent, the	3	Robert William	Wa1ker									n O'Bri				
MD 21215-0036 12 should be filed within 7 th and Mental Hygiens 27 is marked other than umaric event, the <u>Medical roots</u>	2	19a. Informant's Name/Relations David L. Woy	ship (Type, Husba									ral Route N Ville,		City or Town 29483	n, State,	Zip Code)
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If Item 27 injary or other traum.		20a. Method of Disposition 1 Burial 2 XX Crematio 4 Donation 5 Other S		emoval fror		Place of Disp crematory or ENWOY Thy INC	other p Fur	ieral	Hom	е,	06/2	Date 0/2011		: Location - Hanove	r, PA	1
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Physician	1	23a. Part I. Enter the disease, o failure. List only one cause	on each lir	ne.	sed the deat										art	Approximate Interval Between Onset and Death
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)	_	tiple Injui to (or as a c	ries onsequence	of):							_			- Bodai
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š 5 a .	3 -	UNPENDED	☐ AN	IENDED												
Records, P.O. Box 68760, The law requires that the death certificate be extent has been signed by the attending physician page 2 should be detached for use as the burial-completed by Dhysician/Madic	ysicianime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Ur	L a	Live bir	nt at time of c	2 🔲	Fetal d Other	eath (Specify		Ectopic	pregnan	cy	2	23d. Date of Month		eay Year
that deta	3	Part il. Other significant condi	tions con	tributing to	death but not	resulting in the	e unde	rlying ca	ause giv	en in Par	t I.					the cause of death? ably 4 Unknown
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fital sicien:	9	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	al Hospi	tal: 1 n	patient 2	ER/Outpatie	ent 3		10	of Death (Resi	idence 6	Other	: Scene
_ # %2 2	ation: 10	27. Manner of Death 1 Natural 5 Per	iding	28a. Date o (Month Jun 17, 2	f Injury Qay Year) 011	28b. Time o 0540 hrs	of Injury			at Work? es 2 ✔	No S	Subject m ide of ca	iade l r		d was	struck by truck on
Division pital or Attendi ours after death. teral Director: /	Certification:	3 Suicide 6 Cou	uld not be ermined		of Injury - At Roadway	home, farm, st	reet, fa	actory, o	ffice bui	ilding, etc						ral Route Number, City csville, MD
Division To the Hospital or Attend within 24 bours after death, To the Funeral Director: completely filled in by the formation of the formatio	alcal C	29a. Certifier 1 Certifying I	aminer:On	To the best the basis of manner sta	f examination	edge, death oc and/or investi	curred gation,	at the ti	me, date	e and placed	ce, and courred at	lue to the ca	ause(s) ite and	and manner	as state	ed. e cause(s)
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01 AC		30. Name and address of perso Victor Weedn MD JD		tant Med		iner 900	W. B	altimo	ore Sti	reet, Ba	altimor	e, MD 21	223			

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Registrar

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		1	_ State	ryland / Depa	artment of He tificate of De		ental Hygid	ene g. N 201	1 22384	
	Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Last)				2, Date of Death	P4 20	3. Time of Death	
	Medic Examin	al	SHIRLEY MARIE W. 4a. Facility Name (if not institution, give street and number)	Tricen	4b. City, Town, or L	ocation of Death	-10UT	4c. County of		
كبريد)		Meritus Medical Conter		HAgersia	2MJ		Wastli		
	Funeral Director		5. Social Security Number 210–24–0925 6. Sex 1 \square M 2 \nearrow F	(In yrs. last birthday) 78 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Mar 19,	1933 P	g. Birthplace (State or Foreign Country) Pennsylvania	
	nd how at	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits	
	Maryla 28a-f s otified	Director	West VA Morgan			rkeley S ————			1 ☐ Yes 2 No	
	vith the 23a or st be n		10e. Street and Number 115 College Avenue		10f. Zip Code	25411	10	g. Citizen of Wh	ust Country? USA	
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event,	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evarried Forces? 1 Yes 2 No If Yes, Give Year or Dates.	lo If	Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto F Specify:	eify Yes or No- Rican, etc.)		American Indian, White, etc. white	
2-00	hours natura dical E	oletec	3 ☐ Widowed 4 M Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation	on ina most of workir	g 1	6b. Kind of Busi	iness Industry	
121	ithin 72 iene. r than ' the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+	lifo DC	NOT use retired) Nurse			Nursi	ng Home	
and	be filed w ental Hygi ked othe ic event, i	l as l	17. Father's Name (First, Middle, Last) David Hannen							
lary	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Roberts Mi	d Number or Rural	Route Number, C	City or Town, Sta	te, Zip Code)	
re, N	1 and 2 s of Health item 27 other tra		Cheryl Carrigo, daughter 20a. Method of Disposition	20b. Place of Dispos	sition (Name of	D	ate 2		City or Town, State	
imo	Pa ant ru		1 ■ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Lake View		PK 6/1//			ille, MD	
Ball	permit. Departi Import any inji		21. Signature of Funeral Service Licensee	AUS	Name and Address 136 E Balt	imore St	, Taney	town, MI	neral Home 21787	
	UE CON		23a. Part). Enter the disease, or complications that caused sheck, or heart failure. List only one cause on each line.	he death. Do not ente	er the mode of dying,	such as cardiac o	respiratory arres	t,	Approximate Interval Between Onset and Death	
	mysician Medical Examiner		disease or condition resulting in death) a. Due t (or as a	consequence of):						
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09	cate be executed physician and s the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):							
9289	rtificate ling phy e as the	/Med	IF FEMALE: 23c. If yes, outcome of	of pregnancy				201 P-1	of delivery.	
. Box 687	Attending Physician: The law requires that the death certifical refeath. sctor: After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as the funeral director.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	Mont	nte of delivery					
ls, P.O.	uires that t n signed b uld be deta		Part II. Other significant conditions contributing to death but NON ST - SCAMENT MADORITION (N	· +	underlying cause give	n in Part I.		acco use contrib	oute to the cause of death? 3 Probably Unknown	
of Vital Records,	The law req	Completed by	congestive Heart forluce				24a. Was an autops perform 1 🗌 Yes 2	pr ned2 de	ere autopsy findings available for to completion of cause of eath?	
ital	iysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 Yes No Hospital: Inpatie	nt 2 ER/Outpatier	Other	e of Death (Check	only one) me 5 \square Reside	nce 6 \square Other	(Specify)	
of \	ng Phys fter this ineral di	ate: To	27. Manner of Death 28a. Date of injury (Month, Day,	y 28b. Time of	f 28c. Injury a work?	at :	28d. Describe how			
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۵	ospital of hours a uneral D	Medical (29a, Certifier 12 Certifying Physician: To the best of r (Check 2 Medical Examiner: On the basis of ex	ny knowledge, death	occured at the time, o	date and place, an	d due to the caus	e(s) and manner	r as stated. to the cause(s) and manner stated.	
	o the H vithin 24 o the F complet	Me	only one) 3 Certifying Nurse Practioner: To the beautiful control on th	est of my knowledge,	death occurred at the	time, date and place	e, and due to the	cause(s) and mar	nner as stated. (Month, Day, Year)	
			MMS 65 an AD		00053	170		06/14/	2011	
1	MA		30. Name and address of person who completed cause of de MARE BARON MD MERITO	s Medicol	Center.	Hageist	WW M	ery port	21742	
2.	Sta Registr		31. Date filed (Month, Day, Year) 32. Registral	's Signature	acked			1		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 22385 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2015 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annupolis Medical Arundel Center TUNE 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1**∑**M 2□ F Months Days Hours 214-52-9390 Feb 3 1949 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinar must be notified at 1 ☐Yes 2 X No Directo Maryland Anne Arundel Annapolis 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 Funeral 211 Parker Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: **Black** 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pepsi Coca Cola Elementary/Secondary (0-12) College (1-4or 5+) Bottling Co. Vending Mechanic O 11th18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Hawkins Clarence Watkins Sr ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 211 Parker Ave Annapolis, Md. 21401 Charlene Watkins(Wife) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of centerry gramatory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6 - 25 - 11Annapolis, Md. Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Miniame Accordence Soulit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1922 Forest Dr. Annapolis, Md. 21401 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / death. 2 ☐ Accident 6 ☐Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours af e Funeral D eletely filled in Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fill Medical 29a. Certifier

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of cent

30. Name and

32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

JUN 2 7 2011

M

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

6

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ene g. n <mark>2011</mark>	22386
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Medic	al	MARY MARGARET WEBBER		JULY	^{Pay} 2011	5:07 P M
	Examir	er	4a. Facility Name (if not institution, give street and number) FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK		4c. County of Deatl	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign
	Director		217-16-2924 1 M 2X F 85 Yrs. Usual Residence of Decedent		March 6,	,1926 Mar	Tand
	land shov	ţ	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-1 notifie	Director	MD Frederick Bruns				1 🏹 Yes 2 □ No
	ith the		10e. Street and Number	10f. Zip Code		Og. Citizen of What Co	
	ems 2	Funeral	2 West Orndorff Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13	21716 Was Decedent of Hispanic Origin? (Sp		Jnited Stat	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	٥	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White	, etc.
2-0	2 hour "natu edical	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation a kind of work done during most of work	ina 1	16b. Kind of Business I	ndustry
121	ithin 7 ene. • than	Som		DO NOT use retired)	9	Culinary	
ŭ 2	lled worker	BB.	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma		
ylar	should be filk h and Mental 7 is marked c raumatic eve	은	Albert S. Linck	Lilly G.	Wickless	3	
Mar	2 shou th and 27 is m traum:	Y		ing Address (Street and Number or Run			
Ġ,	and 2 Health tem 2		Harold Webber Jr. (Son) 5920 20a. Method of Disposition 20b. Place of Disp	Picnic Woods Rd.,		on, MD 21/5	
m o	Page 1 ment of ant: If i		d XI Burnial A D Commention A D Bornoul from State Cemetery crit	ematory or other place) n Reformed Cem. 7/			
Baltimore,	permit. Page Department Important: I any injury or once.			eeney & Basford P .06 E. Church St.,			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate
	Physician/	100	Immediate Cause (Final disease or condition				Interval Between Orset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):				
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	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
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rds	equire een si nould	eted			1 🗆 Yes	^	obably 4 Unknown
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<u>=</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical	26. Place of Death (Chec.	1	No 1 ☐ Yes	2 No
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J Of	ling P. After ti funera		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury 28b. Time of injury injury	work?	28d. Describe how	injury occurred	
Siol	Attenc r death ctor: ,	Certificate:	Accident Investigation Suicide 6	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Stre	et and Number or Run	al Route Number
	tal or after al Dire		4 Homicide determined building, etc. (Specify)		City or Town,		
-	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 of the physician of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director, page 2 of the funeral director functions are supplied to the funeral director function of the funeral director function of the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death Medical Examiner: On the basis of examination and/ex inversion only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date and	place, and due to the c	ause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number		d. Date signed (Month)	
	h.		* Xalor L. Rayman	D-1397/		7/8/11	
	10 th		30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. Robert Kaufmann, 300 W. 9th Str		arvland 2	1701	
į	Stat Registra		31. Date filed (Month, Day, Year) JUL 1 3 2011 Security 32. Registrar's Signature.				
	ricgistic	1	OUL - U LOTT				

			For State	State of Marylan				Mental Hyg	leg. No. 20	11 22387
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	peatn	2. Date of Deat		3. Time of Death
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	Medic Examin		4a. Facility Name (if not institution, give stree	,		4b. City, Town, or	Location of Death		4c. County	
-	<u> </u>		ANCHORAGE NURSING			SALISBU			WICOM	
b	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 N	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign Country) Maryland
	nd how at	r	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits
	farylar 8a-f s tiffed	Director	Maryland Wicomico	E	den					1 🗆 Yes 2 🕱 No
	the N a or 2	I Di	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	h with ns 23e	Funeral	32369 Flowerhill	Church Road		2182	2		USA	
	r death			Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian,
036	s afte ral", c Exam	ed by	3 Midowed 4 □ Divorced	1 ☐ Yes 2 K No If Yes, Give Year or Dates.	1	☐ Yes 2 🏿 No	Specify:		Specify:	white
5-0	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	plete	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busines (Specify only highest grade completed) (Give kind of work done during most of working							siness Industry
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	filed within al Hygiene. d other tha went, the I	Be (17. Father's Name (First, Middle, Last)		rall	er	18. Mother's Nam	e (First, Middle, M		
ılan	d be fil dental irked tic ev	၀	Howard Wright					na Colli	,	
Maryland	2 should be file th and Mental I 27 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print) Debbie L. Rogers/granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 32369 Flowerhill Church Rd., Eden, MD 2							
	and 2 s Health tem 27		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	1			City or Town, State
im0	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		emetery cren Swerhi Semeter	latory or other place Church	6/24	4/2011	Eden,	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Proce Licensee	CFCP	22	Stewart 1 821 West	uneral H	ome by F	Holloway MD 2180	and Downey,PA
23a. Part 1. Enter the disease ocomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between		
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89	ath certifica attending p for use as t	Ž.		if yes, outcome of pregnar		1			23d. Date	e of delivery
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P.O.	at the		g ☐ Unknown Part II. Other significant conditions contrib		Ilting in the III	nderlying cause giv	en in Part I	220 Did tol	and une contri	bute to the cause of death?
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cor	The law requires ate has been sign page 2 should be	24a. Was an autopsy performed? 1 \[\text{Yes} \ 2 \] \ \ No \ 3 \] \ Probably \ 4 \[\text{Volknowledge} \] \ Yes \ 2 \[\text{No} \ 3 \] \ Probably \ 4 \[\text{Volknowledge} \] \ Yes \ 2 \[\text{No} \] \ \ No \ \ 1 \[\text{Yes} \ 2 \] \ \ No \ \ 1 \[\text{Yes} \ 2 \] \ \ No \ \ Yes \ 2 \[\text{No} \]								
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of V	≥ .⊵ ₽	e: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ I	28b. Time of	28c. Injury	4 Nursing Ho	ome 5 Reside		
ou	anding eath. or: Afte he fun	licat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 ☐ No			
Division of Vital Records,	al or Attending P s after death. I Director: After t d in by the funer	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	 Place of Injury - At hor building, etc. (Specify) 	me, farm, stre	et, factory, office		28f. Location (St City or Town		r or Rural Route Number,
Ω		Medical	29a. Certifier 1 Certifying Physician	: To the best of my knowle	edge, death o	ccured at the time,	date and place, ar	id due to the cau	se(s) and manne	r as stated.
	the H thin 24 the Fi		(Check 2 ☐ Medical Examiner; 0 only one) 3 ☐ Certifying Nurse Pro	ctioner: To the best of my	knowledge, d	leath occurred at the	time, date and place	e, and due to the	cause(s) and mar	
	다 한 한 한		Dec M	· D .		057	-952		06/16	(Month, Day, Year)
	3°C		30. Name and address of person who compl	eted cause of death (Item	23a) (Type, P	rint) ST: #	952 504B,	Salis	burg	21804
I	Stat		31. Date filed (Month, Day, Year)	32. Fegistrar's Signate	ure	ale			/	
	Registra		OVIT NO COLL	1	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O Dorothy Elizabeth Watson 22 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1) (comico ISbury pastal Hospice If Under 1 Yea 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 🗆 M 2 🏝 F 90 Months Days Hours 08/16/1920 West Virginia 233-68-3863 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 21804 USA 32214 Shavox Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black White etc. 1 Never Married 2 Married ğ Docothy F. いなすらの Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper/Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Myrtle Clipp Raymond Furr 19a. Informant's Name/Relationship (Type, Print)
Sharon Marshall/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32214 Shavox Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 6/23/2011 Salisbury Crematory Salisbury, MD 21. Sign, ture of Funeral Service Licensee Holloway Funeral Home Professional Association X hompoor 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MAHONANT COLON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) led by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence HOSPICE 1 🗌 Yes ပ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28c. Injury at 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: work? Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of certifier 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C Physician/ Tyaunna Wilson 1523 Medical Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death Center regional Medicas Salisbury WICOMICO Social Security Number ∠ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Mary lano Months Days Min. (Month, Day, Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Berlin 28a-f Worcester 1

Yes 2 □ No 10e. Street and Number 10f, Zip Code 6 10g. Citizen of What Country? Funeral 23a 8336 Circle Road 21811 USA 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. **African**– 2 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier is marked other t n/a n/a Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adrian Wilson, Sr. Destiny Collins permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Destiny Collins/mother 8336 Circle Rd., Berlin, MD 21811 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Paul's Cemetery 6/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ severe disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying and -transit in competent cervix that the death certificate be executed Cause (Disease or iinjury that initiated events 7.557 hCe Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? After this certificate [1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🔲 Yes 2 X No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D 3005T 04/20/2011 masii

Registrar

DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Riverside Dr. Salisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lind Sa4

MD

gistrar's Signature

lary Beth

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Walker runson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bethesda County of Death **Examiner** If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreigr **Funeral** 1 □ M 2 🛣 Min. Country) 01112211935 SC 76 **Director** Usual Residence of Decedent 10d. Inside City Limits XX 1 ☐ Yes 2 ☐ No iral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State MD 10b. County 10c. City, Town or Location Bethesda Directo Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20817 Funeral 6530 Democracy Blvd USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐ Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black X Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jennie B. Brockington Philip H. Brunson, Sr 19a. Informant's Name/Relationship (Type, Print) nephew Phillip Brunson III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Upland Dr Richmond, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Lawn Cem. 1 Denation 5 Other Control 4 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot June 24, Richmond, VA Denation 5 Other (Specify) 2011 22. Name and Address of Facility 814 Franklin Greene Funeral St Alexandria 21. Sigrature of Funeral Service Litense Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical •• I or Attending Physician: The law requires that the death certificate be a sifter death.
• Director: After this certificate has been signed by the attending physicis d in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🛩 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

1.0-10 State

Truong Bao 10110 Molecular Dr. Suite 206 Rockville MD 20850 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

JUN 2 9 2011

arsuo, mo

Registrar

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00057124

29d. Date signed (Month, Day, Year)

6/8/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 2011 Page 14 0027 a M Baby Girl Williams 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 9. Birthplace (State or Foreign Country) MD 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday 1 M 2 XF Months 6-13-2011 Ming Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location

10f. Zip Code

16a. Decedent's Usual Occupation

1 ☐ Yes 2 XNo Specify:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Unk

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates.

tink^{1 | Yes 2 | No}

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc

SpeBlack

Unk

1500 Forest Glen Rd, Silver Spring MD 20910-1484

Funeral Director 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at ō items 23a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. To Be Completed by Baltimore, Maryland 21215-0036

Physician/

Medical

Examiner

For State Registrar

None

10e. Street and Numbe

11. Marital Status

Unk

1 Never Married 2 Married

3 Widowed 4 Divorced

10a. State

Unk

Funeral Director

Physician/ Medical Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-trar signed by the at Id be detached for within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s

To the Hospital or Attending Physician; The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

15. Decedent' (Specify only highest			16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business Industry		
Elementary/Seconday (0-12)		College (1-4 or 5+)	None	T use retired)			No	ne	
17. Father's Name (First, Middle, Las	st)		None		18. Mot	her's Name	e (First, Middle			
Unk							Will			
19a. Informant's Name/Relationship	(Type,	Print)	19b. Mailing Ad	Idress (Street					r Town, State, Zi	p Code)
Jemeare Willi	iam	s/Mother	Unk	,						•
20a. Method of Disposition		20h E	lace of Dienocition	(Name of			Date	20c. L	ocation - City or	Town, State
1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		noval from State c	emetery, cremator	mator	TC :	Unk		Do	ver, D	E.
21. Signature of Funeral Service Lic	-	7	22. Nar	ne and Addr			W. I		ella S	
M)C	=	2 /s	Ben Fun	nie S eral	mith	Sal	isbur	У,	MD 218	01
23a. Part 1. Entering disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	omplica ly one c	Extreme	Prematu	2 (5)81	ng, such a	s cardiac o	r respiratory a	ırrest,		Approximate Interval Between Onset and Death
1		Due to (or as a consequ	8900							
Sequentially list conditions, cause. Enter Underlying	b. •	Incompet		Vix						
cause. Enter Underlying Cause (Disease or iinjury		Due to joi as a consequ	rence or j							
that initiated events resulting in death) Last	с.	Due to (or as a consequ	ience of):							<u> </u>
	d									
IF FEMALE:										
23b. Was decedent pregnant in the past 12 months?	23c.	If yes, outcome of pregna 1 Live Birth 2 Feta	Ideath 3 🗌 Ect	opic pregnar	су				23d. Date of de	elivery Day Year
1 ☐ Yes 2 🔀 No 9 ☐ Unknown		4 ☐ Pregnant at time of c 9 ☐ Unknown	ieath 5 🗆 Otr	er (specify) _					6	13 2011
Part II. Other significant condition	s contril	buting to death but not res	ulting in the under	lying cause g	iven in Par	t I.	23e. Did	tobacco	use contribute to	o the cause of death?
							1□	Yes 2	No 3□F	Probably 4 X Unknown
							24a. Was	s an		utopsy findings available
							per	opsy formed?	death?	completion of cause of
25. Was case referred to medical				26 F	Place of De	ath (Check		2 X _ N	lo 1 ∐ Ye	s 2X No
examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hos	oital:	ED/Outpatient 3	T _{Ot}	ner	20,000		idonae	6 ☐ Other (Spe	off d
27. Manner of Death		28a. Date of injury	28b. Time of	28c. Inju	ry at		28d. Describe			sity)
1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat		(Month, Day, Year)	injury N	4 1 E	k? Yes 2	□No				
3 Suicide 6 Could no 4 Homicide determine		28e. Place of Injury - At ho building, etc. (Specify		actory, office			28f. Location City or To	(Street ar	nd Number or Ru	ıral Route Number,
TWO .	1									
(Check 2 Medical Exa	aminera	 n: To the best of my knowledge of the basis of examination ractioner: To the best of my 	and/or investigation	on, in my opin	ion, death	occurred at	the time, date	and plac	e, and due to the	cause(s) and manner state
29b. Signature and title of certifier			g-,wiii	29c. Licens					ate signed (Mont	
1000	9	1	~	DES	509				1.11/11	

DHMH 17 Rev 7/2009

State Registrar Cross Hospital,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Holy

Janel Hino,

11-05079	
Tigran Akopian	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate	of Death		Reg.	Z U 1 1	26336
Physici	an/	Decedent's Name (First, Middle,Last)			2.	Date of Death		3. Time of Death
ledical Exam	iner	Tigran David Akopian				Month D July 8, 2011	ay Year	0132 hrs
		4a. Facility Name (if not institution, give street and number	r)	4b. City, Town, or Lo	ocation of Death		4c. County of Death	
		10401 Grosvenor Place		Bethesda			Montgomery	
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)			8. Date of Birth (MM/DD/YYYY) 9. Birt	
Director		216-33-1235 1XM 2DF	29	Months Days	Hours Min.	December	14 1981 Cou	ⁿ ^{Intry)} Armenia
		Usual Residence of Decedent				December	17, 1501	
any		10a. State 10b. County	10c. City, Town or Lor	cation				10d. Inside City Limits
nd show	_	D.C.		Washingto	on	200		1 X Yes 2 No
faryland 28a-f show I at once.	듗	10e. Street and Number	-	10f. Zip Code		70g.	Citizen of What Coun	try?
th the Maryland 23a or 28a-f sho notified at once.	Director	2939 Van Ness Street, N.W.	#1201	200	800	1	United S	States
with with 18 23		11. Marital Status 12. Was Deceder	nt Ever in U.S. 13. \	Was Decedent of Hispa		ify Yes or No-	14. Race - Americ	
leath item	uneral	1 X Never Married 2 Married Armed Forces	6? 2 X No	f Yes, specify Cuban, M	Mexican, Puerto Ri	can, etc.)	White, etc.	
fter d	щ	3 Widowed 4 Divorced If Yes, Give Yaar		Yes 2X No s	specify:		Specify: Wh:	ite
vurs a Itura	d by	15. Decedent's Education (Specify only highest grade co	mpleted) 16a. Deced	dent's Usual Occupation			6b. Kind of Business/Ir	ndustry
72 hc	Completed	Elementary/Secondary (0-12) College (1-4 or	5+) during	most of working life. De	O NOT use retired	1)		
5-0036 ed within 7. tygiene. other than	ם	2	Arc	hitectural	Draftsma	an	Archite	ecture
5-0036 led within 7 Hygiene. I other than	S	17. Father's Name (First, Middle, Lest)		18.	.Mother's Name (F	irst, Middle, Mai	den Surname)	
21215-0036 uld be filed within 72 hours af Mental Hygiene. marked other than "natural to event, the Medical Examin	Be	David B. Akopian			Ada V. A	Azaryan		
AD 21215-00; 2 should be filed within and Mental Hygiene. 27 is marked other thematic event, the Med	ပ္	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street a	and Number or Run	al Route Numbe	r, City or Town, State,	Zip Code)
MD id 2 shoulth and m 27 is summeti		David B. Akopian / Father		01 Grosveno				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Heath and Mornell Hygiers in Companies of Heath and Mornell Hygiers (map virus), or items 23a or 28a-faha injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from S		oosition (Name of cemet other place)	etery, [Date 2	Oc. Location - City or	Town, State
Page lent o		4 Donation 5 Other Specify:		Crematorium,	Inc. July	14 2011	Rathaeda	Maryland
Baltimore, permit. Pages l ar Department of Hee Important: If itel		21. Signature of Foreran endo Licensee	22	Name and Address of	f Facility_	1 11 1	Dechesda,	vy Chase, Inc.
E E A E		MUNICIA M	01619	557 Wiscons	nrey runera sin Avenu	ie. Beth	esda. Marv	vy chase, He.
Physician		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death. Do not ente	er the mode of dying, su	uch as cardiac or re	spiratory arrest,	, shock, or heart	Approximate interval Between Onset and
/Medical :xaminer		Immediate Cause (Final disease a. Multiple	Injuries					Death
:Xaiiiiiei		or condition resulting in death) Due to (or as a cons						
	L	Sequentially list conditions, b						
	ē	if any, leading to immediate Due to (or as e conscause. Enter Underlying Cause	sequence of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	sequence of):					
cuted ind transit		d		_				
a- a	Medical	x UNPENDED AMENDED 23a	a,27,28a-f,	per me,g918	8-11-11	sm		
760, icate be ex physician the burial	Æ		me of pregnancy				23d. Date of delivery	
	an	23b. Was decedent pregnant in the past 12 months?		Fetal death 3	Ectopic pregnanc	y	Month D	ay Year
Box 687 death certification the attending	Sic	1 Ves 2 No 9 Unknown	t time of death 5	Other (Specify)				
he to he	Physician/		th but not resulting in the	a underlying cause give	en in Part I	23e Did toba	cco use contribute to t	he cause of death?
ires that the signed by the detact	Ď	Contributing to doc	ar bac not resulting in the	o undonying cause give	orrary art.		2 ✓ No 3 Prob	
duire quire en sig	ted					24a, Was en		opsy findings available
ords, aw requi as been s	B					autopsy	prior to c	ompletion of cause of
	Completed					performe	ed? death? No 1 ✔ Ye	s 2 No
Vital lysician:	Be	25. Was case referred to medical examiner?			Death (Check onl			
₩ ₩	2	1 ✓ Yes 2 No	ent 2 ER/Outpatie	ent 3 DOA	ther Mursing H	lome 5 🗌 Re	sidence 6 🗹 Other	Scene
	Ë	27. Manner of Death 1 Natural 5 Panting 28a. Date of Inj (Month, Day)	ury 28b. Time o Year)		_ c		v injury occurred precipitat	od from
trend teath.	atic	2 Accident Survestigation Accident Fd 7-8-	-11 fd 1:	27 am 1 Yes	h	eight		
Division tal or Attendi 13 after death.	ij	3 Suicide 6 X Could not be 28e. Place of I	njury - At home, farm, st	reet, factory, office build	ding, etc. 28	or Town State	et and Number or Ru	rel Route Number, City svenor Place
Hospital 24 hours : Funceral tely filled	Certification:	· Hornicide	sidence		#	122T B	ethesda,Md	·
e Ho		29a. Certifier (Check only 1 Certifying Physician: To the best of n						
	.=	one) 2 Medical Examiner: On the basis of examiner and manner stated						
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	9			29c. License n	number	2	9d. Date signed (Mor	th Day Year)
Division To the Hospital or Attent within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature end title of certifier	200		_			,,,,
1	Med		Del s	O.C.M.	E.		July 8, 2011	, ==,, . • • · ·
or rest	Med	29b. Signature end title of certifier 20. Name and eddress of person who completed cause of		O.C.M.				,,
Hopkey		29b. Signature end title of certifier Pot Signature end title of certifier 30. Name and eddress of person who completed cause of Patricia Aronica-Pollak MD. Assistant I	death (Item 23a) Medical Examiner	O.C.M.				
Hopkey	ate	29b. Signature end title of certifier Potton 30. Name and eddress of person who completed cause of Patricia Aronica-Pollak MD. Assistant I		O.C.M.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22393 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 21:54 PM ILLIAM ADAMS プレレ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bayview Medical Center Johns Hopkins Baltimore If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Country) Ohio (Month, 1 M 2 D F 8 Months Hours Min **Director** 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State must be notified at Director 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Mariţal Status Examiner Black White etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ပ unk unk 19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2036 Balto Dolla 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposi Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signatur Juneral Service Ligensee Name and Address of I neval Home, ate 21216 D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween DAY Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEVMONIA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) the a g Unknown g 🗌 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the lirector, page 2 s autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Hospital 2 No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certi DES-000 7011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ne Baltimore, Md

DHMH 17 Rev 7/2009

State Registrar MD

GZAMAM

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 ear 20:35 M SHAFI ALIZAI MUHA MMAD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL HOSP COLUMBIA HOWARD COUNTY HOWARD Social Security Numbe . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-75-1153 Months Days Hours 1 № M 2 🗆 F Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director 1. Yes 2 ☐ No OWAR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be MANOR STONE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: *A5114* 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CCOUNFING AKISTAN GASCO 1 and 2 should be filed with Health and Mental Hyginitem 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ ALIZAI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TENE LN. COLUMBIA, MD 21544 ZHMIRA 37 MIANOR permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Column birt millimicial roluMBIH, 6 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fune al Service License 22. Name and Address of Facility 116 000 De FIRMOUND HOUME GUILFORE 23a. Par.1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner EDEMA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) FAILURE RENAC tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit STAGE Hospital or Attending Physician: The law requires that the death certificate be executed END that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ျ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 050404 MAR 2011 PHYSICIAN

State Registrar PATUXENT

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COULMBIA, MD

21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10632

PATEL

4

31. Date filed (Month, Day, Year)

LITTLE

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b&d PerFH &26 Per PHY G91/7/14/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A SINAI HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.7/10/1929 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ITALY 216-44-4723 Vrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, It of Marical Examination injury or other traumatic event, It of Marical Examinations MD BALTIMORE N/A BALTIMORE XX Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 2601 STEELE ROAD 10f. Zip Code 21209 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important; if item 27 is marked other than "any injury or other trainmeth." College (1-4or 5+) Elementary/Secondary (0-12) SURGEON MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RIMINI GIUSEPPE ASCOLI CLARA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 STEELE ROAD, BALTIMORE, MD 21209 19a, Informant's Name/Relationship (Type. Print) MARIA GRAZIA ASCOLI/WIFE Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other place)
CARROLL CREMATION,
INC. 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 07/11/2011 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) NSON & BROS., INC. PIKESVILLE, MD 21208 22. Name and Address of Facility SOL LEVI 8900 REISTERSTOWN ROAD, 21. Signature of Funeral Service I Approximate Interval Between Opset and Dear 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 /Medical Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): 68760, Physician/Medical signed by the attending p Box IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the lying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown Yes 2 🗌 No cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home Tesidence 6 Other (Specify) 1 ☐ Yes ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To After thi funeral of 27. Manner of De h 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner elated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number State Registrar

ORIGINAL

Thinh 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22396 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Iantha 11.25 PM Baker 2011 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Agnes If Under 1 Year I If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 213-34-7878 Months 74 06/24/1937 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 USA 4116 Edmondson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: Black 1 ☐Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Brooks Amos Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Bakers Lane, Pasadena, MD 21122 Eric Brown / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/15/2011 Final Journey Crem. Woodbine, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall W. Marshall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nemia neck disease or condition resulting in death) Due to (or as a consequence of):)ehydration week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of gall bladder Adeho car cino ma Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

items 23a or 28a-f show

ral", or it Exar, in

event, the Medical

injury or other traumatic

Department of Health a Important: If item 27 is any injury or other trainonce.

"natural"

I Hygiene.

Pages 1 and 2 should be filed venent of Health and Mental Hygirint; If item 27 is marked other

Director

by Funeral

Completed

Be

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with the Maryland

filed within 72 hours after

3altimore, Maryland 21215-0036

burial-tran death certificate be execu attending physician for use the detached signed t d be deta

page 2 should has certificate funeral After t death. ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Physician/Medical Completed Be Certification: To Medical

To the within 25.

Hospital or Attending

State Registrar

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

28c. Injury at Work?

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier MD

D 6458-3

29d. Date signed (Month, Day, Year) 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nisupana D-900 Caton Arenue Hospital 32. Registrar's Signature 31. Date filed (Month, Day,

4 Homicide

(Check only one)

29a. Certifier

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Julv Agnes Johns Bradlev 2011 7:10 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Year 1 M 2 X F Months Days Hours Min Director 212-22-2493 83 Dec. Usual Residence of Decedent 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 □ No N/A Baltimore Marvland ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 6011 Hunt Club Lane U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò ō 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give and 2 should be filed within 72 hours after 1 Yes 2 X No Specify "natural", Completed I 3 X Widowed 4 □ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Morris Johns Emilv Rawlings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Susan B. Boutilier (daughter) 816 Bellemore Road Baltimore, Department of Healt Important: If item 2 any injury or other t Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 7-14-11 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
6500 York Road Baltimore, Maryland Signature of Funeral Service Licensee 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21212 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Vobable disease or condition resulting in death) Medical Dut to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown signed by the atter Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myclodyspinsone syndrome 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one)

requires that the death certificate be Division of Vital Records, P.O. Box 68760 certificate has been the Hospital or Attending Physician: funeral within 24 hours after death.

To the Funeral Director: After completed filled in by the

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Certificate:

Medical

29a. Certifie

(Check

altimore, Maryland 21215-0036

examiner? Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1 Anatural 2 Accident 5 Pending 1 Tes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

15

only one re and title of certifier 29b. Signata

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

N. Charles

Other:

29d. Date signed (Month, Day, Year)

DONSUN MO

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

31. Date filed (Month, Day, State 1 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per FHG917 //14/2011 JH
State of Maryland / Department of Health and Mental Hygiene
AMEND TEM#18perry, C919, 9/8/2011, WS

Certificate of Death

Reg. No. 2011 For State Registrar 22398 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day James Sylvester Burke 9:45 P M July 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 130 Hollow Brook Rd. Timonium Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Hours Min (Month, Day, 1 X M 2 □ F 215-22-7132 **Director** 82 Dec. MD 1928 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Timonium MD Baltimore **Tinmonium** ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral 21093 130 Hollow Brook Rd.. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engrg. Assistant Bell Atlantic Telephone Be 18. Mother's Name (First, Middle, Maide (1977) gan 17. Father's Name (First, Middle, Last) ပ္ Thomas Leo Burke Theresa Sheila Kerrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Burke/daughter 130 Hollow Brook Rd., Tinmonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 7/16/11 cemetery, crematory or other place) Donation 5 - Other (Specify Timonium, MD Valley Memorial Gardens 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (final disease or con on Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Line, Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 2011 pleted cause of death (Item 23a) (Type, Print) DULANEY 2300 4 2011 State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar 22399 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 July 9:10 Marlyn Busch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Min. Oct II Day, 1 M 2 🗓 F 1940 Maryland **Director** 214-38-5731 70 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 977 Punjab Circle 21221 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 XMarried δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manager 7-11 Convenience Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Maxmillon Peter Koelbel Mildred Lasseth Weaver 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Cheririco - daughter 717 Clover Valley Ct; Edgewood, Maryland 21040 Saltimore, **&** 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fire of Service Licensee Naylor 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or i that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Unknown 9 🗌 Unknown Hospital or Attending Physician: The law requires that the signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MARLYN BUSCH 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsv perform death? 24 hours after death.

Funeral Director, After this certificate leted filled in by the funeral director, pag 2 🗌 No 2 **X** No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 🔲 Yes 2 X No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 Yes 5 Pending 2 🗌 No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pleted f within to the F 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 7/2009

State

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

erson who completed cause of death (Item 23a) (Type, Print)

JONES.

4

JACKIE 31. Date filed (Month, Day, Year) CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 1 - For State Registrar Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NE 0520 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Linthicum Tate House 5. Social Security Number 6. Sex 8. Date of Birth
(Month, Day, Year)
Dec 15, 1949 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Days Hours Min. **Director** Yrs 556**-**86-1713 61 Dec Rhode Island Usual Residence of Decedent 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Arno1d Anne Arundel 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral USA 111 Cresston Rd. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 XDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) machine operator factory injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ James Loren Daggett Leta Mae Stanhope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11 Cold Springs Dr; Manchester, PA 17345 permit. Page 1 and 2 st Department of Health ar Important, If item 27 is any injury or other trau Deanna Fetz - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Daviel 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Ph sician/ ALUNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy detached for Month Year Pregnant at time of death Day Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No hours after death uneral Director; / 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of pertifier Date signed (Month, Day, Year, d cause of death (Item 23a) (Type Print) MAm 441 IEN 31. Date filed (Month, Day, Year) State 1 4 2011 Registrar

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ore	of Heal of Heal fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Disposition cemetery, cremator	n (Name of	Date		Location - City or	Town, State
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Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		21. Signature of Funeral Service er	see M	22 No	me and Address If Fa	Russ	Funera		
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			307 Jame and appress of person who	completed cause of death (Itel	m 23a) (Type, Print)	0		+ 0 1	(- 1 1 2 : 2 5
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	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					1

James William Cox, Jr. State of Maryland / Department of Health and Mental Hygiene 2011 22402 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner July 10, 2011 1628 hrs James William Cox 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 506 E. 32nd Street **Baltimore** Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of **Funeral** Months Days Min. Director May 15, 1953 Country) Maryland UNKNOWN 1X M 2 F 58 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Baltimore City **Baltimore** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21218 United States 506 E. 32nd Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White, etc. 1 Yes 2 X No WHITE 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Auto Repair Auto Body Repair Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lottie Cook James Cox ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4327 Falls Road, Baltimore MD 21211 Lottie Ccok- MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 07-13-11 Metro Crematory INC Baltimore Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road, Baltimore MD 21228 IN Physician Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a. Hyperthermia complicating Chronic Alcohol Abuse Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last e attending physician and for use as the burial - transi Physician/Medical UNPENDED AMENDED the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown ned by the a detached fo Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) å examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes ဥ 2 No 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Exposure to high environmental temperatures FOUND: 5 Pending 1 Yes 2 ✓ No hin 24 hours after death. Director: Jul 10, 2011 2 Accident 1620 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 506 E. 32nd Street, Baltimore, MD determined (Specify) Multi-Family Apt 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 11, 2011 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

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x 68 th certi tendin truse a	past 12 months?	4 Pregnant a	t time of death 5		(Specify)	Ectopic pregna	aricy	4	Month	Day Y	/ear
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Division of Vital Records, I at or Atteoding Physiciae: The law requires rs after death. at Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed.							24a. Wa			ere autopsy findings a	
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Physici r this o	1 Yes 2 No			tpatient 3		ner ₄ Nursin	g Home 5	Resid	ence 6 🗸	Other: Scene	
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isio r Attec er deat rector 1 by th	2 Accident Invest	igation 28e Place of In	ijury - At home, fai	rm, street, fa			28f. Location	(Street	and Number	or Rural Route Numb	ner City
Division o spital or Atteoding nours after death. oeral Director: After filled in by the func Certification:	3 Suicide 6 Could 4 Homicide deterr	not be					or Town,				,,
		ysician: To the best of m	y knowledge, deal	th occurred	at the time, date	and place, and	due to the cau	ıse(s) a	nd manner a	s stated.	
To the Ho within 24 To the Fu complete	one) 2 Medical Exam 29b. Signature and title of certifier	and manner stated.	auon and/of III	vosugation,	29c. License nu		ate			(Month, Day, Year)	
	Down to K. I	Lull MA			O.C.M.E				y 13, 201		
	30. Name and address of person v	who completed cause of d	leath (Item 23a)		L						
	Pamela E. Southall, Mi			900 W	. Baltimore S	treet, Baltir	more, MD 2	21223			
Ctate	31. Date filed (Month, Day Year)	32 Registre	r's Signature	_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year har rumart 4:29 PM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Secours MATIMOR N/A Depart Emergency If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth **Funeral** n yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 □ F Min. 0 7 7 2 3 7 19 5 6 unk 54 Hours Florida Yrs **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f 1√2 Yes 2 ☐ No MD N/A Baltimore ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 205 N. Carey St. Apt 2 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) years 3 Cab Driver self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Cromartie Mary Lou Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau N. Carey St. Apt 2, Dana Roberson(son) 205 Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State on-site 4 ☐ Donation 5 ☐ Other (Specify) Crematory 07/06/11 Baltimore, MD Signat re of Funeral Service Licenses osephodis of Brown Jr. Funeral Home 140 N. Fulton Ave., Baltimore, 子 2140 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ acute disease or condition muccardial Medical resulting in death) Examiner attensal work Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş putin5/on Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes 2 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 \square Pending injury work? 1 ☐ Yes 2 🗌 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier avaa

J M State

Registrar

Marcia

COx

31. Date filed (Month, Day, Year

4

Scionos Hospital

32. Registrar's Sig

2000. W. Raltimore Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar		epartment of Health and Certificate of Death	Mental Hygiei Reg.	7 1 1	22405
I	Physicia	an/	1. Decedent's Name (First, Middle, La	1 (1)	1	2. Date of Death Month	Day Year	3. Time of Death
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	and show	٥	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
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	with th	Funeral I	412 Woodla	Ko Ct	10f. Zip Code	10g.	Citizen of What Cou	untry?
10	72 hours after dea th with the Maryland n "natural", or items 23a or 28a-f sho tedical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Ameri Black, White	
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Man	2 should th and Ma 7 is mar traumati		19a. Informant's Name/Relationship (7	ipe, Print) Daught 19b. M	Mailing Address (Street and Number or Ru	ral Route Number, City		
	e 1 and 2 s of Health If item 27 or other tra		20a. Method of Disposition	20b. Pace of D	Disposition (Name of	Date 20c	Location - City or T	Town, State
Baltimore,	G = = >		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	b) Pinela	wn Memoria 7 -	5-2011 Fu	rmingda	1e NY
Ba	permit. P. Departme Importar any injur.		21. Signature of Funeral Service Licens	Anusning Pantrison	BIANCH 814 US	hurst Nu	U WASH I	11006 1
ı			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	olications that caused the death. Do not ne cause on a ch line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
e de la companya de l	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	nec			Onset and Death
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Box 68	ath certific attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	very Day Year
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Records, P.O.	or Attending Physician; The law requires that the death certificate be executed after death. After death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions of	ontributing to death but not resulting in t	he underlying cause given in Part I.		o use contribute to t	he cause of death?
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Re	sician; The law in certificate has kinector, page 2 s		25. Was case referred to medical			performed		
Vita	Physicia this cert al direct	To Be	examiner? 1 🗆 Yes 2 🖼 No	Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Checation 3 DOA Other:	ome 5 Residence	6 Other (Specif	Y) TATE.
o u	nding Pt th. : After th : funeral	cate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tim inju		28d. Describe how in	jury occurred	House
Division of Vital	I or Attend after death Director; /	Certificate:	3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street : City or Town, Sta		
٥	To the Hospital o within 24 hours af To the Funeral Di completed filled in	Medical (29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, der	ath occured at the time, date and place, a	nd due to the cause(s)	and manner as state	ed.
	the Ho thin 24 the Fu	Mec	(Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of examination and/or in	nvestigation, in my opinion, death occurred age, death occurred at the time, date and pla	at the time, date and pla ace, and due to the caus	ace, and due to the ca se(s) and manner as s	ause(s) and manner stated. tated.
	F 3 6 8		29b. Signature and title of certifier	mo	29c. License number	29d. I	Date signed (Month,	∪ay, Year)
/			30. Name and address of person who c	ompleted cause of death (Item 23a) (Typ	pe, Print)	V. 1.	1000 - 1 -	MD 21401
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	45 Defense	Juy. 17/	IN APOLIS	140 21401
	Registra	r	JUL 1 4 2(111 12	Level -			

State of Maryland / Department of Health and Mental Hygiene 2011 22486 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Madical Examiner 1005 hrs Donna Lynn Dorsey July 9, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 5120 South Street Elkridge **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Director Min. 220-64-4266 2|X |F 46 1 M Jun. 7, 1965 Country) MD Yrs. Usual Residence of Decedent In y 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Howard 1 Yes 2 X No Elkridge death with the Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 5738 Main Street 21075 United States or items 23a 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes hours after 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify: "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I tent of Health and Mental Hygiene. College (1-4 or 5+) event, the Medical Baltimore. MD 21215-0036 12 Office Clerk H & M Distribution 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Barry Charlotte Pawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Dorsey - Husband 5738 Main Street, Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) X Burial 2 Cremation 3 Removal from State 7-14-2011 Longaine Park Woodlawn, MD on 5 Other Specify 21 Signature of Funeral Service 22. Name and Address of Facility M rose uneral flome, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alcohol and Diphenhydramine Intoxication Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease a.complicated by drowning Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, g917 7-19-11 sm attending physician or use as the burial The law requires that the death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? <u>م</u> <u>ت</u> 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed Records. 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has 2 s performed? death? certificate l' ector, page Yes 2 ✔ No Yes Haspital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other Scene this 2 No 1 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural ingested alcohol and sleep-aid 5 Pending 1 Yes 2 X No fd 7-9-11 fd 9:46 am tablets and entered water 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide 6 Could not be or Town, State)Patapscork Elkridge,Md Valley State To the Huspital or within 24 hours af To the Funeral D completely filled i determined (Specify) Homicide creek 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 10, 2011 lldv 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD State 4 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $July^{ ext{Month}}$ Linda Thelma DePasquale 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Min. 214-54-4630 Hours Country Mary land Director 61 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1627 Schuckes Road 21015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Charles Harthausen Thelma Folks and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael W. DePasquale 1627 Schuckes Road, Bel Air, Maryland 21015 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other 1 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 7-16-11 Baltimore, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Tage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): mets this burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate 1 Yes 2 No 1 🗆 Yes 2 🔼 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes မ 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier Medical doctol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGELITO ESTADILLA 500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

MOCCO-1003

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Record

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jul-Irene Dembroski AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BEL AIR HARFORN HEALTH AND REHABILITION CENTE Funeral If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 127-12-6051 1 □ M 2 🂢 F Months Days Hours April15. New York Director 96 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director New York **Oueens** Woodside 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 48-24 43 Street 11377 U.S.A. the Medical Examiner must "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White, etc þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Ford Motor Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve any injury or other traumatic eve Joseph Zidek Anna Zidek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Baron 1324 Springvale Drive ,Bel Air, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calvary Cemetery 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Woodside New York 7-16-11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) lew isks Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial by Physician/Medical $\Sigma M BROSKI$ I RENCE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56545 11/11 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 615 W. MACPHAIL RD #106, BELAIR, 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

1 4 2011

State of Maryland / Department of Health and Mental Hygiene State Registrar 22409 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10° 2011 ear JďľŸ 6:24 A M ROBERT EDWARD DENIKE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore County GILCHRIST HOSPICE CENTER Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec 26, 1927 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Hours 374-24-3353 1 💢 M 2 🗆 F Michigan Director 83 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits the Maryland Director 1 Yes 2 X No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event. the Medical Examina. Funeral 2523 Girdwood Road 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Unk Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) USF+G Vice President Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Robert DeNike Thaler Mary Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 220 Gaywood Road, Baltimore, Maryland 21212 (Daughter) Lisa D. Ercolano 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 7/13/2011 Green Mount Crematory Baltimore, Maryland 21. Signatura Europa Server Server Server Server Martin D. Lawson TICHECE WIEDEFELD FUNERAL 6500 York Road, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPTRATION PNEUMONTA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OSTEDMUEITIE Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed METASTATI Due to (or as a consequence of): resulting in death) Last /sician a e burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the t anding pure IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Withnown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed 2 🗌 No Yes 2 N 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes ER/Outpatient 3 DOA HONA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Matural 5 Pending after death. Director: Af 1 Yes 2 No Accident Investigation the within 24 hours after de To the Funeral Directo completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) Medical 29a. Certifier 🛮 🧲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tit 29d. Date signed (Month, Day, Year) 01 30. Name and address person who completed cause of death (Item 23a) (Type, Print) ATHL filed (Month, Day, Year) 11 1 4 2011 6705 NORTH CHARLES SULTE 4105 STREET State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year arion Medical u 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BayVILW Hopkins are Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug. 18, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X 83 216-20-6116 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5514 Heatherwood Road 21227 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Payroll Clerk Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o William Berg Johanna Bauer permit. Page 1 and 2 should be Department of Health and Men' Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Wolf - Daughter 5514 Heatherwood Rd., Baltimore, MD 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Purial 2 ☐ Cremation 3 ☐ Removal from State cemetery frematory or other place) 4 Donation 5 Other (Specify) Memorial Park 7-14-2011 Elkridge, MD Sign Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 SUlphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death orona Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown the þ s been signed to should be det-Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Rehab (Onte ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Yaws Villa C person who completed cause of death (Item 23a) (Type, Print)
THBC 5505 Hopkins Bayview arde, Builtimore

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State Registrar 32. Fagistrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month Physician/ 3: 25 A M 07 12 2011 DNEY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A LEVINDALE HEBREW HOME BALTIMORE 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 □ F Days Min. 1 1 1 1 9 7 1 9 2 2 218-18-3374 88 Yrs **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified ** once. 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 USA 2 STONEHENGE CIRCLE #5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FURNITURE SALESMAN Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) SEGALL EPPEL SOLOMON HANNAH ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STONEHENGE CIRCLE #5, BALTIMORE, MD 21208 CHARLOTTE EPPEL/WIFE 13dd 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition ANSHE EMUNAH AITZ CHAIM 07/13/2011 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Matt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NUESTIVE Physician/ MEGAT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed' 2 No certificate 1 Yes Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident 1 Yes 2 No 1 24 hours after death.

E Funeral Director: A pleted filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number MYSICIAN 120064533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE MEGALW BABATUNDE AJAN 1 2434 W. BELVESERE BAUTIMORE 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 22412 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death July Month 2011 Physician/ MICHAEL SOMERSET FITCHETT 12. 10:05P Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 03/28t/1954(ear) Maryland 1**XX** M 2 □ F 57 **Director** 216-66-7249 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location notified at Director 1 Yes 2XX No Baltimore Maryland Baltimore 10f. Zip Code 21239 10e. Street and Number 10g. Citizen of What Country? the Medical Examiner must be 6311 Banbury Road Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceded Armed Forces? Yes 2XX No 1XXNever Married 2 Married by White 1 ☐ Yes 2 XXNo Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1/14 or 5+) Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elizabeth Dillon Thomas Somerset Fitchett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6311 Banbury Road Baltimore, Maryland 21239 19a. Informant's Name/Relationship (Type, Print) Sister Elizabeth Karen Maccabee 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XXCremation 3 ☐ Removal from State 07/14/2011 Baltimore, Maryland GreenMount Crematory ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Examine by Physician/Medical Be Completed

Ph. sician/ Medical **Examiner**

28a-f show

items 23a

ō

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

ģ Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: At completed filled in by the fu

၉

Medical Certificate:

29b. Signature and title

31. Date filed (Mont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMES

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

disease or condition resulting in death)	ue to (or as a consequence of):		months
Sequentially list conditions, if a year a second cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
		24a. Was an autopsy performed?	
25. Was case referred to medical	26. Place of Death (Che	ck only one)	
examiner? 1 Yes 2 No	ospital:	Iome 5 Residence	6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 \(\text{Yes} \) 28c. Injury at work?	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
(Check 2 Medical Examine	ian: To the best of my knowledge, death occured at the time, date and place, a ear. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	at the time, date and plac	ce, and due to the cause(s) and manner state

58303

N Charles

29d. Date signed (Month, Day, Year)

rouson un

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State Registrar 6701

MM

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 | | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	ito or maryian	Cer	tificate of	Death	and wichter	Re	eg. No.	
Physici Podical Exam		Decedent's Name (First, Middle						Date of Deat Month	th Day Year	3. Time of Death
eqicai Exam	mer	Debra And 4a. Facility Name (if not institution	rews Harri	.S		Ib City Town	or Location of De	July 9, 201	11 4c. County of Deat	1428 hrs
		1703 East/West Highw	-	, oi)	1	Silver Sp		auı	Montgomery	
Funeral		5. Social Security Number 6	6. Se x 7.	Age (In yrs. la	ast birthday)	If Under 1 Y		Hrs. 8, Date of Bir	th(MM/DD/YYYY) 9. Bir	
Director		220-50-8655	1 M 2 X F	48	Yrs.	Months D	ays Hours	Min. Januar	y 3, 1963 Wasf	
h		Usual Residence of Decedent						Junuar	y cycle wast	
ow any		10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits 1 X Yes 2 No
Aaryiand 28a-f show 1 at once.	tor	Maryland Mon	tgomery			Ke	nsington		0g. Citizen of What Cou	
or 28	Director		. 1	A	# 006	TOI. ZIP GOOR	20895			
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Ta	10225 Freder 11. Marital Status	12. Was Decede			Decedent of		(Specify Yes or No-	United St	ates ican Indian, Black,
leath r item	uneral	1 Never Married 2 Mar	ried Armed Force	es? 2 X No			oan, Mexican, Pue		White, etc.	,,
after	by F		rced If Yes, Give Year		1 🗆	Yes 2X	No specify:		Specify: Wh	ite
hours natur Exam		15. Decedent's Education (Specif					pation (Give kind life. DO NOT use		16b. Kind of Business/	Industry
)36 thin 72 te. than '	ple	Elementary/Secondary (0-12)	College (1-4	or 5+)	Тоог	h			Virginia Cou	ntu Cabaala
d with	Completed	17. Father's Name (First, Middle, L			Teac	ner	18.Mother's Na	me (First, Middle, N)	illy schools
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur e event, the Medical Exam	Be	Don Darrell A 19a. Informant's Name/Relationshi	ndrews, Jr				M	argaret E	H. Harrison	
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once		Don Darrell And 20a. Method of Disposition	lrews, Jr.		12 Mo			t. #102, R	ockville, N	faryland 20850
Ges 1: t of H	- Ø	1 X Burial 2 Cremation	3 Removal from	State Cr	rematory or oth	er place)				
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		4 Donation 5 Other Special Signature of Funeral Service Li		Parl	klawn Men				Rockville,	
Depa Depa	7	John My	-	— _{м013}					Bethesda—Chev/ Maryland 208	y Chase, Inc.
Physician	-	23a. Part I. Enter the disease, or co								Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a Methadon	e Intox	xicatio:	n				Death
	Н	or condition resulting in death)	Due to (or as a con	nsequence of)	:					
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uted uted id ansit		events resulting in death) Last	d.	isequence or)						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	X UNPENDED	AMENDED 23	a,27,28	Ba-f,pe	r me,g9	919 9-9-	ll sm		
760, icate be ex physician the burial	/We	IF FEMALE:	23c. If yes, outo	come of pregna	ancy				23d. Date of deliver	,
ox 687 eath certifi	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	at time of dea	=		BEctopic pre	gnancy	Month [Day Year
Box 68 e death certif the attending ed for use as	Physician/	1 Yes 2 No 9 V Unkno	9 Unknown		⊃ Oth	er (Specify)				
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Dipital ours at filled	Certification:	4 Homicide determine		Mult	i-fami]	Ly apar	tment	#419 Si	treet and Number or Ru ate)1703 East 1ver Sprin	g,Md.
								nd due to the cause	(s) and manner as state	ed.
To the within To the comple	Medical	29b. Signature and title of certifier	and manner state		aror investigation		on, death occurre	u at the time, date a	and place, and due to the	
i. \		A A A	11 11	<u> </u>			C.M.E.		29d. Date signed (Mor July 10, 2011	ли, µау, теаг)
3 of Our	-	30. Name and address of person when the same and address of person when the same are address of person are address.	ocampleted cause of	death (Item ?	(3a)					
2 hay		The second secon	Assistant Medic			Baltimore	Street, Baltim	ore, MD 21223	3	
		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	Kad					
Regist	7-12	11 11 11 11 11 11 11	1 Duestin 16	a supplied						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death ent's Name (First, Middle_Last) Date of Death Physician/ Medical ndlnumber) not institution, give street City, Town, or Location of Deat County of Death Examiner Birthplace (State or Foreign Country) f Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 XF June 26, 213-34-2348 74 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 Funeral 701 Edmondson Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. Specify: I Hygiene. other than "natural", 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) dishwasher hospital Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk n and Mental H မှ should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st ment of Health a tant: If item 27 is 611 Central Ave; Towson, MD 21204-4299 Donna Brill - legal guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🕅 Other (Specify) in state. 21. Signature of Funeral Service Licensee
Daniel A Nay 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Curt 23a. Part 1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of) sician and bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buna P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Furnatal Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BSTRUCTIVE DIS EAST TULMONARY Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number nn Name and address of person who completed cause of death (Item 23a) (Type, Print) SmiTH AV 2835 ANI m 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 9:58 PM FAITH A. FORD 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Agnes BALTIMORE CITY Hospita Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 M 2 K F 71 5, 1940 MARYLAND Director 214-38-5086 MAR. Usual Residence of Decedent 10d. Inside City Limits 10b. County show 10a. State 10c. City, Town or Location s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL BROOKLYN PARK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 UNITED STATES 609 HOPKINS STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify Specify 3 Widowed 4 N Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES RETAIL CLERK 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCES LEWIS WILLIAM LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 312 WILD WILLOW RD., SEVERN, MARYLAND 21144 JAMES W. FORD, JR. / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot JULY 16, 1 □ Burial 2 I Cremation 3 □ Removal from State CATONSVILLE, MARYLAND METRO CREMATORY, INC. 4 Donation 5 ☐ Other (Specify) 2011 21. Sign Runeral Suvice Licensee KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bilateral 5 days **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transi Due to (or as a consequence of) ng physician a P.O. Box 68760, Physician/Medical the attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🖵 🗖 o 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2□M6 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide l 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Caton Ave 31. Date filed (Month, Day, Year) Pecistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		For State Registrar	State of	Maryland	l / Depa <i>Cen</i>	artment of F tificate of L	lealth and Death	Mental Hy	giene 0		22416
Physic	ian/	1. Decedent's Name (First, Middle, Antoinette	Last)	-	Farin	acci		2. Date of Dea	ath Dav	Year	3. Time of Death
Med Exam	lical	. = 100	give street and number			4b. City, Town, or	Location of Dea	July 9	2011 4c. County	of Death	10:30 A ^M
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Funera Directo		213-32-9337	1 ☐ M 2 💢 F	Age (In yrs. las 75	Yrs.	Months Days	Hours Mir		11,1935	9. Birti Cou West	nplace (State or Foreign ntry) Virginia
and show	١	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
e Maryl r 28a-f notifie	Director	Maryland N/	A		Balti	more_			40. 0"		1 X Yes 2 □ No
s 23a o	Funeral		treet			101. 21p code	21224		10g. Citizen of USA	vvnat Col	intry?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	å	1 Never Married 2 Marr	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? X No	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo		Specify Yes or No- rto Rican, etc.)		ck, White,	
15-0 72 hou n "natu fedical	Completed	15. Deceden (Specify only higher	t's Education st grade completed)		(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most of wo	orking	16b. Kind of B	lusiness Ir	ndustry
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land be filed ental Hy ked oth	To B	17. Father's Name (First, Middle, L. Nicolas Christp	,					ame (First, Middle, lette Moc		e)	
e, Maryland 21215-0036 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", o ther traumatic event, the Medical Exam		19a. Informant's Name/Relationsh Angela Farinacc	ip (Type, Print)	er				dural Route Number			
Baltimore, cernit. Page 1 and Department of Her Important: If item and injury or other page.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)	ate cer	netery, crem	sition (Name of eatory or other place rk Cemet e		y ^{Date} 14, 2011	20c. Location Baltimo	-	
Baltimo		21. Signature of Fureral Service of	gense // Kan	M0117	(c) 22	Name and Address Onnelly 1	Funeral	Home Of I	Dundalk	P.A.	21222
cate be executed Medica Examination Physician and stree burial-transit	Examiner	shock, of heart failure. List of Immediate Cause (Final dise or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Due to (or b. Due to or	as a consequel	nce of):	Heart	FAI	LURE			Interval Between Onset and Death
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Division of Vital Records, tal or Attending Physician: The law requires rs as redeath. al Director Affer this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was autop perfo	rmed?	prior to c death?	opsy findings available ompletion of cause of
of Vital P Physician:] this certifice ral director, p	Be	25. Was case referred to medical examiner? 1 Yes, 2 No	Hospital:	patient 2 □ E	D/Out-ation	Othe	ace of Death (Ch				
ion of \text{ter ding Phydesth.} tor After this the funeral d	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of (Month, ation		8b. Time of injury	28c. Injury	/ at	Home 5 Residence 28d. Describe h			
Division transmission rists are restricted and Director led in by the		3 Suicide 6 Could r 4 Homicide determi	ned 28e. Place of	Injury - At hom , etc. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rur	al Route Number,
To the Hospital of within 24 hours at To the Funeral Documental Completed filled in	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the bes caminer: On the basis Nurse Practioner: To	of examination a	and/or investi	gation, in my opinic eath occurred at the	on, death occurred e time, date and p	d at the time, date a	nd place, and due cause(s) and m	e to the canner as s	ause(s) and manner stated. stated.
To Sor		29b. Signature and title of certifier	4.14	hh	m	29c, License	6360	5	JULY	9 (Month,	2011
/		30. Name and address of person w	tho completed cause	of death (Item 2 Row I	3a) (Type, Pr	67011	1, ChAR	eurs STP.	er BA	LTIPM	ice MOZIZIA
St Regist	ate rar	31. Date filed (Month, Day, Year)		istrar's Signatur	e 1 1					De la constantina	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c #22 Per FH G917 7/14/2011 JH State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician /Medical 30 AM 2011 De CCa Ke 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 9, 1937 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Maryland 74 212-36-9538 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 28a-f show perriti. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Decartment of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Baltimore MT 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21202 501 E. Preston St; #413 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: black 1 ☐ Yes 2X No 21215-0036 Specify: þ 3 Widowed 4 X Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Shangri-La Nursing Home nursing assistant 10 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Sarah Williams Henry Kinnard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2827 Windsor Ave; Baltimore, Maryland 21216 19a. Informant's Name/Relationship (Type. Print) Ruth Williams - aunt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7/15/2011 1 ☐ Burial XXCremation 3 ☐ Removal from State
4 ☐ Donation 5 € Ojner (Specify) 1 1 5 € 3 € C Joseph Geriocks Fine 1302 Central Ave 21202
655 W. Baltimore St; Baltimore, MD 21201 Greenmount 23a. Part 1. The line disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-tran Due to (or as a consequence of) attending physician 68760 Physician/Medical the SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death Box 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death
9 Unknown Day 5 Other (specify) 2 X No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 3 Probably 4 Unknown 1 Yes completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence Hospital: 2 No 3 DOA 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 1 Yes မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division within 24 hours after death.

To the Funeral Director: After or Attending 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide determined 4 Homicide Hospital 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bradsher 600 North Wolfe St, Baltimore, MD, 21287 -obert 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUL 1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year harle 235 AM 101 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AGNE TIMORE HOSPI 6. Sex 9. Birthplace (State or Foreign Country) Maylan If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 M 2 □ F (Month, Day, Ye 54 65 Director yland Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country Funeral MOUN 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 1 No Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates partment of Health and Mental Hygiene.

outant: If item 27 is marked other than "natuinjury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) (seneral Truck Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Thom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Nu City or Town, State, Zip Code) Yana Frei permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee fevin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest A proximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Lower extrem Physician/ tocellulitus 01 disease or condition resulting in death) Medical Examiner ud omonas a exoginosa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Osteomyelitis attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 子名た Y , C H A A L にら Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown page 2 should be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy pertension 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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AVENUE, BALTIMORE

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		1 - For State Registrar	State of Mary		artment of H tificate of D		l Mental Hy	giene Reg. No. 2011	22419		
Physi /Med		1. Decedent's Name (First, Middle, Last)		G	oyan	la a di Para	2. Date of Dea	Day Year 2011	3. Time of Death 3:55 A M		
Exam		4a. Facility Name (If not institution, give si The Johns Hopkins Hos			4b. City, Town, or Baltimore		ath *	4c. County of Dea	un		
Funera Directo		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year) Co	rthplace (State or Foreign ountry) AZ		
and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	cation				10d. Inside City Limits		
th with the Marylan 23a or 28a-f show ist be notified at	cţo	VA LANCASTER		WHITE STONE					1 ☐ Yes 2 ☐ No		
vith the	Director	10e. Street and Number			10f. Zip-Code			10g. Citizen of What C	ountry?		
death v ms 23¢ must t	Funeral	1626 JAMES WHARF RE	Was Decedent Ever	in U.S. 13. V	22578 Was Decedent of His f Yes, specify Cubar	spanic Origin?	(Specify Yes or No-	14. Race - Am			
fand 21215-0036 Jid be filed within 72 hours after death with the Maryland fental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	ģ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates:	1	f Yes, specify Cubar □ Yes XX No	specify:	erto Rican, etc.)	1000	te, etc. HITE		
15-0	eted	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	luring most of w	vorking	16b. Kind of Busines	s/Industry		
vithin iene.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	me. L	TEACHER			EDUCATION			
Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Examir.	Be C	17. Father's Name (First, Middle, Last)						, Maiden Surname)			
aryla	ည	LEONARD SPOONER 19a. Informant's Name/Relationship (Type)	e Print)	19b Mailin	ng Address (Street a		A BUTLER Rural Route Numb	er, City or Town, State,	Zip Code)		
	1	GEORGE VICTOR GUYAN	o	I	JAMES WHAR			•	-,,		
		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place		Date	20c. Location - City o	r Town, State		
Baltimory permit. Pages Department of I Important: If its any Injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign (18 of Funeral Service License		BAYVIEW CRI			3.2011	BALTIMORE, M			
Depart June 2009		K. CRECORY FINK	M0114	8 FIN	NK FUNERAL I 5 CRAIN HWY	HOME, P.A SW GLEN	N. t/a MARYI BURNIE, MD	AND MORTUARY 21061	SUPPORT		
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the cause on each line.	death. Do not ente	er the mode of dying	g, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death		
hysician physician as the burial-transi	edical Examiner										
death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	-		23d. Date of d Month	elivery Day Year		
det de t	þ	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did 1	obacco use contribute Yes 2 No 3 🗆 I	to the cause of death? Probably 4 Unknown		
HeC le law has b	Completed					_	24a. Was autop perfo 1 Yes				
	Be	25. Was case referred to medical examiner?	ospital:		Othe	AF.	eath (Check only o				
Phys this	은	1 ☐ Yes 2 ☐ No	28a. Date of Injury	2 ER/Outpatien	f 28c. Injury	at Inursing		dence 6 Other (Sp how injury occurred	ecify)		
VISION OT VITA Attending Physician: or death. ector: Affer this certific by the funeral director,	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	M 1 🗆 Y	? ∕es 2 ∐ No					
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	pecify)			City or Tov				
Hospi 24 hou Funera etely fill	Medical		ician: To the best of my ier: On the basis of exa and manner stated	amination and/or inv							
To the Hos within 24 hd To the Fun completely	Mec	29b. Signature and title of certifier	and mainly diated	·	29c. License	number		29d. Date signed (Mor	nth, Day, Year)		
1.		1/1/			RES	- 000		July 11 2	.011		
V			-(1)		Print)	60	0 North Wo	olfe St, Baltim	ore, MD, 21287		
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's	olynature							

JULY 11, 2011 12:33 p.m.

JOYCE GOETZINGER

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			For State Registrar	State of N	/larylar		artmen tificate			and M		giene Reg. No.	011	22420
	Physicia	n/	1. Decedent's Name (First, Middle,		0 .						Date of Dea Month		Year	3. Time of Death
,	Medic	al	Joyce 4a. Facility Name (if not institution,	Lorraine		zinger	4h City	Tours or	Location of	of Dooth	July	11	2011 County of Dea	
-	Examin	er	Stella Maris	- ,				oniu		DI Deatii			Baltimo	
	Funeral Director		217-26-5189	6. Sex 1 \(\text{M} \) 2 \(\bar{\mathbb{X}} \) F	ge (In yrs. I 81	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da July 2.	y Vonr	9. Bi 929 Ma	orthplace (State or Foreign ountry) aryland
	ind ihow at	or	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation							10d. Inside City Limits
	Maryla 28a-f s atified	rect	MD. Baltir	nore	Gle	n Arm								1 ☐ Yes 2X No
	th the	Funeral Director	10e. Street and Number	711 D			10f. Zip	Code 1057	,			10g. Citi;	zen of What C USA	ountry?
	eath wi	nue	4037 Holly I	12. Was Deceden		S. 13. V				gin? (Spe	cify Yes or No-	1	4. Race - Am	erican Indian.
920	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marri	Armed Forces	?	If	Yes, spec				cify Yes or No- Rican, etc.)	1	Black, Whi	te, etc.
5-0	2 hour "natur	plete	15. Deceden (Specify only highes	t's Education		16a. Deced	ent's Usua			t of worki	na	_	nd of Business	
2121	I within 7; ygiene. her than it, the Me	e Completed	Elementary/Seconday (0-12)	College (1-4 or	5+)	Homema	O NOT use	retired)					Home	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours aftr of Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exar	To B	17. Father's Name (First, Middle, La Thomas Bacon	ast)						er's Name argai	e (First, Middle, cet Co	Maiden S Wen	iurname)	
, Mar	nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationsh Gary Goetzinger,				•				i Route Numbe 7e Glen			•
nore	age 1 ar ant of Hu tt: If iter y or oth		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	e c	Place of Disposemetery, crem	natory or or	ther plac		، -15-	Date _ 1 1		cation - City o ${f imore}$.	
3altir	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.		4 ☐ Donation 5 🔀 Other (S ₁) 21. Signature of Funeral Service Li			11y Hi					ineral Towson			
	#D= #0	Н	23a. Part 1. Enter the disease, or o	complications that caus	ed the deat	h. Do not ente	r the mode	050	York	Rd.	Towson	, MD	21204	Approximate
, Line	Physician/ Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. END ST	ne. AGE D	EMENTI/								Interval Between Onset and Death
- age	Examiner		4	Due to (or a	s a consequ	uence or):								
	pe sit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or a	s a consequ	uence of):								
	execut an and rial-trar	ical Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a consequ	uence of):								
09	ate be ohysici the bu	dica		d									_	
9289	certification of the second of	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								2	3d. Date of d	aliveny
Вох	he death or y the atter ched for u	nysicia	in the past 12 months? 1 ☐ Yes 2 👿 No 9 ☐ Unknown	1 Live Birth 4 Pregnant 9 Unknown	at time of		Ectopic p Other (sp		у				Month	Day Year
s, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	Part II. Other significant condition	ns contributing to death	but not res	sulting in the u	nderlying o	ause giv	en in Part	l.	23e. Did to		در	o the cause of death?
cord	aw requas beer 2 shou	plete									24a. Was		24b. Were a	utopsy findings available completion of cause of
Re	: The la	Con									perfo	ormed?	death?	
ita	sician certifi irector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:		FD(0 : ::	🗆 ==	Othe	ace of Dear	,				
of V	g Phy er this neral d	te: To	27. Manner of Death	28a. Date of in	jury	ER/Outpatien 28b. Time of		Bc. Injury	4 ⊔ Nu ≀at	-	me 5 ∟ Resid 28d. Describe h		_	cify) HOSPICE
ion	tendin eath. or: Aft the fur	ificat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could n	ation	ay, rear)	injury	M	work	? Yes 2 🗆	No				
Division of Vital Records,	al or At s after d al Direct ed in by	l Certificate:	4 Homicide determi	28e. Place of Ir	njury - At ho etc. (Specif)		et, factory	, office			28f. Location (S City or Tow		Number or R	ural Route Number,
7,	the Hospital or thin 24 hours afte the Funeral Dire mpleted filled in I	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of Nurse Practioner: To the	examinatio	n and/or invest	igation, in r	ny opinio	n, death oc	curred at	the time, date a	and place,	and due to the	cause(s) and manner stated.
4	To the within To the Comp		29b. Signature and title of certifier	10 n Chai	P		29c.	License	number (G7	92		29d. Date	signed (Mon	1
	0)		/ (the completed cause of		n 23a) (Type, P) 	TTMON	JTIM	MD 210		11/0	• 1
	Stat		31. Date filed (Month, Day, Year)			ture fact		<i>.</i>	1 THU	TUM,	ED 210	U73		
	Registra	ir	JUL 1 4 20	III Sergia	Jo.	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 22421 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ALICE GREEN - PERRY Physician/ Month 201 0440 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 💢 F 253-54-159 Director 5.C. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Halethorpe MD BALTIMORG 1 XYes 2 ☐ No 10e. Street and Number OAKLAND TERRACE ROAD 10g. Citizen of What Country? Funeral 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🛪 No If Yes, Give Black, White, etc. 0 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) HOUSE WIFE PRIVATE College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental I em 27 is marked o HERMAN BASTON BEOWN ESTELLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode)
1216 OAKLAWO TOKKACE RU HAIEHWOK, NO 21221 19a. Informant's Name/Relationship (Type, Print) meodoes PEREN - HUSBAND Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 Date 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 07-13-2011 BICKDINNIMO 4 ☐ Donation 5 ☐ Other (Specify) BUCKTOWN -BAZZEL CEM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 401 ALMSNUNG-PATIGROW BIANCH 814 UPSING STNW WASH, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final PSIS Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RY FAILURE Sequentially list conditions, if any leading to in neutrale cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Box (23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 D No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown BETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hospital or Attending Physician: The certificate 2 No 1 Tyes Vital Be 25. Was case referred to medical was case received examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IEN MD 724 Marden Choicelane

DHMH 17 Rev 7/2009

State Registrar

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			1- For State of Maryland / Department of Health and Mental Hygien 2011 22 Certificate of Death Reg. No.	422
	Physicia Medic		Thomas Eduin Hongou Month Day Year	ne of Death
de .	Examir		4	
1	Funeral Director	Г	5. Social Security Number 2.18-22-4106 1x M 2 F 83 Yrs. 1 M 2 F	
	yland f show ed at	itor	Usual Residence of Decedent	de City Limits
	the Mar r or 28a- se notifie	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Yes 2 X No
	ems 23ar must t	unera	202 Oakwood Road 21222 USZ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14, Race - American Indian	
9036	ırs after de ural", or it ıl Examine	þ	1 Never Married 2 Married 1 Ves 2 No	
1215-(thin 72 hou the. than "nat than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 16c. Bus Driver Transporta	tion
and 2	be filed wi ental Hygie ked other c event, ti	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	119	19a. Informant's Name/Relationship (Type, Print) Lori J. Horsey / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Oakwood Rd., Dundalk, MD 21222	
more,	Page 1 and nent of Hea int: If item iry or othe		20a. Method of Disposition 1	e
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Tremation Services Maryland PO Box 1413, Baltimore, MD 2120.	3
	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx Interval	
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Liver Disease Onset a Due to (or as a consequent of):	
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. E. In a Cause (Disease or injury) Cause (Disease or injury)	
	icate be executed physician and s the burial-transit			
8760	tificate b ng physi as the b	Medical	d	
Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 1	Year
P.O.	is that the gned by be detacl	by	23e. Did tobacco use contribute to the cause	
ords	v require s been s should	Completed	1 Yes 2 No 3 Probably 4	ngs available
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ייסר	ling Phy n. After this funeral c		The imparative 2 is Envolupation (3 is box) 4 is intuiting Horne 5 is Residence 6 is other (specify)	
Division of Vital Records,	or the flospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Certificate:	2 Accident Investigation M 1 Yes 2 No Suicide Accident A	umber,
 -	e Hospita 1 24 hours e Funeral	Medical	29a. Certifier (Check (Check only one) 29a. Certifier (Check only one) 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	d manner stated.
	Nithi To th		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 7/7/1)
1	,	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory Levichary 1120 N. Rolling RD Bollo MD 212.	4 F
	Stat Registra	·	31. Date filed (Month, Day, Year) 32. Registrar's Signature	•
	negistra	1	JUL 1 4 2011 James D. Source	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22423 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -ASLUP ORIS 8-01PM 2011 JULY Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SLEM 184 WASHINGTON MEDCAL RNIE ANN E ARYNDEL Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 T fonth, Day Days Maryland Months 219-26-3775 Director Mar. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Glen Burnie Maryland Anne Arundel 1 🗆 Yes 2 📉 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 313 Hospital Drive 21061 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ò 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 White 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced "natural" Specify Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than event, the N Elementary/Seconday (0-12) College (1-4 or 5+) 11 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) nt of Health and Mental H t: If item 27 is marked ot or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Ambrose Winkler Ada Shock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8041 Crainmont Dr. East, Glen Burnie, MD 21061 Boba Hollifield / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò Department of Important: If any injury or once, Metro Crematory Inc. 07/12/2011 Baltimore, Maryland Signature of Funeral Service Licensee ${f Alyson}\ K$ 22. Name and Address of Facility Cremation Society of Mary and Taylor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Rd., Baltimore, Maryland 21228 Approximate Interval Between Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner SCHEMIC BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events VASCULAR DISEASE burial-transit ATHEROSCUEROTIC resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: ase 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown for Month Year Dav the detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş CMCEPHALOPATHY Completed 1 Tyes No 3 □ Probably 4 □ Unknown een ATKIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page this certificat ☐ Yes 2 🗙 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

7

State Registrar PAPHAEL D
31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

MIGHWAY SOUTH ## GIGH BURNIES MD 206

			Please Type or Famend	rint in l Items# Marylan Item#	Black Ir 18, 19a 19a Depa Cer	delible in per fh, priment of i tificate of i	k, Ensyre g <u>917 - 1</u> Jealth <u>a</u> nd Death	All Copies 8-11 sm Mental Hyg	s Are Le	gible.	22424
A A	Physicia Medic		1. Decedent's Name (First, Middle, Last) Helen L. Hunt					2. Date of Dea	ath		3. Time of Death 7:45 A M
7	Examin		4a. Facility Name (if not institution, give street and number Oak Crest Care Center	er)		4b. City, Town, o	r Location of Deat	th		ty of Death	
10	Funeral Director		5. Social Security Number 441-44-1030 6. Sex 1 M 2 1 F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min				place (State or Foreign htry) SGS
	yland •f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County Manual and Baltimore		y, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2X☐ No
_	the Mar a or 28a be notifi	al Director	Maryland Baltimore 10e. Street and Number	Fai		10f. Zip Code			10g. Citizen o		
-21	ath with	Funeral	8832 Walther Blvd Apt 231	nt Ever in II 9	13 \	21234	lispanic Origin? (S	Specify Yes or No-	U.S. <i>E</i>	ace - Ameri	can Indian.
t	Parkville 10a. State 10b. County Parkville 10c. City, Town or Location Parkville 10c. Street and Number 10c. Street and								ack, White	etc.	
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125	within giene. er thai		Elementary/Seconday (0-12) College (1-4	or 5+)	Teac				Educa	tion	
v H u N T 7 7. Maryland 21215-0036	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Richard Stewart		T		Jessis Jessis	ame <i>(First, Middle,</i> Briggs Briggs			
	d 2 should alth and Me 27 is mar er traumati		194 Thomas Name/Relationship (Type, Print) Arron L. Hunt / Daughter		1	ng Address (Street • Luray		ural Route Numbe exandria			22301
L.E.	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 [X Cremation 3 ☐ Removal from S	ate c	emetery, crer	sition (Name of natory or other pla	i	Date 4 / 2 0 1 1	20c. Locatio		_
HELE / Baltimore,	permit. Pa Departme Importan any injury once.		4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee	H1 / /-	22	Serv. Co	ess of Facility Ru	4/2011 ck Towso	n Fune	al Ho	ome, Inc.
	D = 60		23a. Part 1. Enter the disease, or complications that ca	sed the deat		050 York er the mode of dyin				2120	Approximate
1	Pnysician/ Medical		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	ASC as a consequ	VD						Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequ	uence of):						
00	e be executed iysician and ie burial-transi	dical Examiner	Cause (Disease or injury	as a consequ	uence of):						
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica		rth 2 🗀 Feta nt at time of c	aldeath 3	Ectopic pregnan Other (specify)	су			Date of deli Month	very Day Year
ls, P.O	uires that the signed by the detact	by	Part II. Other significant conditions contributing to dea	th but not res	ulting in the u	underlying cause g	iven in Part I.		obacco use co		the cause of death?
Record	The law req ate has bee page 2 shou	Completed								b. Were aut prior to death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of 2 DNO
ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 In In		ED/0-1	Ott	Place of Death (Ch	eck only one) Home 5 Resi	c 🗆 c	When (Consider	6.4
n of V	iding Phys th. : After this s funeral d	cate: To	27. Manner of Death 28a. Date of	patient 2 injury Day, Year)	28b. Time of injury	28c. Inju wor	ry at	28d. Describe			
ivisio	I or Atter after dea Director	Certificate:	3 Suicide 6 Could not be 28e. Place o	Injury - At ho , etc. <i>(Specif</i> y		eet, factory, office		28f. Location (S City or Tov		mber or Rur	al Route Number,
Ø.	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best only one) 3 Certifying Nurse Practioner: To	of examination	n and/or inves	tigation, in my opin	ion, death occurred	d at the time, date a	and place, and	due to the o	ause(s) and manner stated.
**	To th withi To th		29b. Signature and title of certifier	C		29c. Licens	se number		29d. Date sig		
	Oj		30. Name and address of person who complete cause ALICE M. BRAZIEP		23a) (Type, I	mp walth	es Blrd	Park	ville	111), 21234
	Stat Registra		31. Date filed (Month, Day, Year) - 27 Rec	istrar's Signa	bar	res .			, 		

Physician /Medical Examiner Examine the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

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or 28a-f show notified at

"natural", or items 23a or edical Examiner must be

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ant of Health and Mental Hit: If item 27 is marked oth y or other traumatic even

permit. Page Department of Important: If any Injury or once.

wffman.

Maryland 2121

Baltimore,

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Pages 1

Director

Funeral

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Completed

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Physician/Medical

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Certification:

Medical

certificate After this funeral of To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Xx ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier (Check only one) 29b. Signature and title of pertifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

2-12849

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alf - GHILADI., M.D. 7600 OSLER DV. TOWSON MD 21204 31. Date filed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Day **Physician** 2:35 AM 1 tubbar 2011 JULIC /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Villa Rosa Nursing Home Mitchellville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 XM 2 □ F Aug. 12, 1937 Ohio 288-34-1989 Director 73 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7003 Copper Sky Court 20772 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Media once. College (1-4or 5+) Elementary/Secondary (0-12) US Postal Service Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Hubbard, Sr. Mattie Montgomery ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothye Hubbard - Wife 7003 Copper Sky Ct., Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Peace Cemetery 7-9-2011 Akron, Ohio 4 □ Domation 5 □ Other (Specify) 21. Signature of Funeral Service Light 22. Name and Address of Facility Stewart & Calhoun Funeral Home 529 W. Thornton St., Akron, Ohio 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Dementia Stage End and Due to (or as a consequence): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Gastrointestina 1 Tes 2

No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1□ Yes 2 2 **Z** No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours at ne Funeral I 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 nd title of certifier 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) FEEE 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thenne Ste 203 Baltmore, Md 2835 Smith Daro MD 31. Date filed (Month, Day, Year) 22. Registrar's Signature State JUL 1 4 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$19b Per FH G917 7/14/2011 JH State of Maryland / Department of Health and Mental Hygien [2] | | 22427 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MORTON C HALLE 12:10 DM 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Sinai Of Hospital Baltimore Bautimore City If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 212-30-2292 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 🗶 M 2 🗆 F Days Hours Min 10/18/1933 MD Usual Residence of Decedent 10c. City, Town or Location BALTIMORE 10a. State 10b. County 10d. Inside City Limits MD BALTIMORE 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3306 BONNIE ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ※ Yes 2 □ No If Yes, Give Year or Dates. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Specify: WHITE 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) FURNITURE SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SIMON HALLE DORIS LISSBERGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code 3306 BONNIE ROAD, BALTIMORE, MD 21209 MARJORIE HALLE/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTTMORE HEBREW 07/11/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Servic, Licentee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Urosepsis disease or condition resulting in death) day

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

physician a use as 1 for signed by the a page

the funeral director.

completed filled in by

within 24 hours after death To the Funeral Director: A

Certificate:

Medical

29a. Certifier

that the death certificate be executed

Box 68760

P.O. I

Division of Vital Records, Hospital or Attending Physician: The law requires

Examine Physician/Medical þ Completed Be ၉

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or imput that initiated events resulting in death) Last IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

Yes 2 No 9 Unknown

insufficiency,

Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus,

Hypothyroidism

9 Unknown

Due to (or as a consequence of)

Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

Chronic renal

SINAI

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Day

Year

24a Was an autopsy performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗷 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yeş 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No

M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

> Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
> 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> > HOSPITAL

29b. Signature and title of certific 29c. License number RES - 000

29d. Date signed (Month, Day, Year) JU14 08, 2011

OF BACTIMORE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABADIWA KATRINIA M.D

31. Date filed (Month, Day, Year) State 4 201 Registrar

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22428 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9:15 P. M 2. Date of Death Physician/ July 2011 Stella Ianuly Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26 Constantine Drive Baltimore Phoenix Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Jan 4, 1922 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 035-12-6839 89 Pennsylvania Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No Maryland Baltimore Sparks 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21152 6 Windmill Chase Apt. H U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 □ Divorced White Completed Specify. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bead Chain Company Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk 2 William Costa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Paul Ianuly 26 Constantine Drive, Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-15-11 Bridgeport, Connecticut Lakeview Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events attending physician and or use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performe certificate 1 Tes 2 No Yes 2 funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tyes 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of De th 1 Watural 2 Accident 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 5 Pending injury s after death.

I Director: Aft Investigation 1 Yes 2 No completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and mainten as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated and place, and due to the cause(s) and manner stated and place are stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person w

31. Date filed (Month

ted cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Maryla		artment of I <i>tificate of L</i>		Mental Hy	giene Reg. N		22429
	Physicia	in/	Decedent's Name (First, Middle, Last) TELLA	1 <h< th=""><th>OLA</th><th></th><th>· -</th><th>2. Date of De Month</th><th></th><th>Year Zoi (</th><th>3. Time of Death</th></h<>	OLA		· -	2. Date of De Month		Year Zoi (3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give stre	eet and number)		4b. City, Town, o	r Location of Dea	07		ounty of Deatl	
			Fairfield Nursing 5. Social Security Number 6. Sex			Crown:	sville Tif Under 24 Hr			nne Ar	
	Funeral Director		215-76-1807	7. Age (In yrs.		Months Days	Hours Mir				thplace (State or Foreign Fyland
and	show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Maryl	28a-f otiffiec	irect	MD Anne Ar	undel S	Severn						1 ☐ Yes 2 ☐ X No
with the	23a or ıst be n	Funeral Director	10e. Street and Number 1681 Meade Villag	e Circle Rd	; #386	10f. Zip Code 21144	4		10g. Citizen	of What Co	untry?
036 rs after death	Department of Health and Mental Hyglene. Impartment of Health and Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	. Was Decedent Ever in U Armed Forces? ↑ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	l I	Vas Decedent of H Yes, specify Cuba	n, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		Race - Amer Black, White ecify: bla	e, etc.
215-C	าก "natu Medical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	ent's Usual Occup aind of work done of NOT use retired)		orking	16b. Kind	of Business I	Industry
within	lygiene. her tha	Be Co	Elementary/Seconday (0-12)	College (1-4 or 5+)	1	hier			Wa	almart	:
land be file	rked of	10 B	17. Father's Name (First, Middle, Last) Emmanuel Hill				18. Mother's Na Etta	ame (First, Middle, H ill	Maiden Surr	name)	
lary should	and M is ma auma		19a. Informant's Name/Relationship (Type,	*		g Address (Street	and Number or R	ural Route Numbe			
and 2	tem 27		Orrin Webb Jr - s		Place of Dispos		Village T	Cir Rd 7		Severn	n, MD 21144
Baltimore, Maryland 21215-0036 Demit. Page 1 and 2 should be filed within 72 hours after	tant: If i	1 3	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 🕅 Donation 8 ☐ Other (Specify)	moval from State	cemetery, crem	natory or other plac					Town, State
permit Description	Impor any in		21. Signature of Jun al Service Licensee	Ter le	22	Name and Addres			-		21201
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of	tions that caused the dea	th. Do not ente	r the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
, N	sician, /ledical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a chised	MUS		CAN	ICER			Onset and Death
Exa	aminer	ē	Sequentially list conditions, b.	Don't de la company							
nted	nd ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	Due to (or as a consec	quence or):						
be exec	physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consec	quence of):						
6/00 tificate b	ng physas the		IF FEMALE:								
LIVISION OF VICE THE COLORS, F.O. BOX 06/100 The Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.	been signed by the attending is should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d.	. Date of deli Month	ivery Day Year
es that th	igned b be deta	by	Part II. Other significant conditions contri	buting to death but not re	sulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
ecords, e law requires	been s	letec		 				24a. Was			obably 4- Unknown
The law	ate has page 2	Completed						auto	psy prmed?	prior to c death?	completion of cause of
ician:	nis certificate I director, pag	Be	25. Was case referred to medical examiner?			Othe	ace of Death (Che		2,92,110		
9 Phys	0 :D	e: 10	1 Yes 2 No Pos 27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury	4 Nursing	Home 5 Resident			fy)
Vittendin death.	tor: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		injury		? Yes 2 □ No				
tal or A	al Directed in by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		et, factory, office		28f. Location (S City or Tov		mber or Run	al Route Number,
n e Ho spi in 24 hou	To the Funeral Director: After thi completed filled in by the funeral	Medical	29a. Certifier (Check 2 Medical Examiner: only one) 3 Certifying Nurse Pl	n: To the best of my know On the basis of examination actioner: To the best of m	n and/or investi	gation, in my opinio	 n. death occurred 	at the time date a	and place and	due to the c	ause(s) and manner stated
To th	To th		29b. Signature and title of certifier Clau) Nº	whan	29c. License			29d. Pate sig	_	
			30 Name and address of person who come	neted cause of death (Item	n 23a) (Type, Pr	DEFENS	E Hw	y ANI	VAPO	ILIS M	12401
, F	Stat Registra		31. Date filed (Month, Day, Year) JUL 1 4 2011	32 Registrar's Signa	8. pa	Nes .		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.					
		1 - State of Maryland / Department of Health and Mental Hygien Certificate of Death Registrar	2011	22430	
		Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death		3. Time of Death	
Physic Med		Patricia Elizabeth Jones Thomas	Your Voor	12:55A M	
Exam		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	c. County of Death		
		Joseph Richey Hospice Baltimore 5. Social Security Number 6. Sex 7. Age (flyrs, last birthday) If Under 1 Year I If Under 24 Hrs. 18. Date of Birth			
Funera Directo		5. Social Security Number 6. Sex 7. Age (III yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplac Country)	Maryland	
now at	<u>.</u>	Usual Hesidence of Decedent			
arylan ka-f sh	ecto	10a. State 10b. County 10c. City, Town or Location		Inside City Limits 1 Yes 2 □ No	
the M or 28	ă	10e. Street and Number 10f. Zip Code 10g. C	Citizen of What Country?		
death with the Maryland ritems 23a or 28a-1 sho	Funeral Director	126 N. Fremont Avenue 21201	USA		
r deat	by Fu		14. Race - American I Black, White, etc.		
036 rs afte	ed b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates.	Specify: Black	L	
555 / 15-0036 72 hours after n "natural", or	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working 16b.	Kind of Business Indust	try	
ithin 7 ene.	Com	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)	6 la 1	DI.	
Maryland 21215-0036 Should be filed within 72 hours after death with the Maryland th and Mental Hygiene. Zi is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	BB	17. Father's Name (First, Middle, Last) 18. Nother's Name (First, Middle, Maider	Surname)	laza	
aryland hould be filed and Mental H s marked ott	<u>ا</u>	Otis Jones Betty Has	skins		
Mar Mar 2 shou h and 7 is m		19a. Informant's Name/Relationship (Type, Print) (Gother) 19b. Mailing Address (Street and Number or Rural Route Number, City of	or Town, State, Zip Code	a)	
and 2 tem 2		20a Mathad of Disposition	MD 213	18	
Baltimore, Mapermit. Page 1 and 2 sh Department of Health ar Important: If item 27 is many injury or other trau once.		1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State	Location - City or Town,		
altij		Curine Cemelory : 113 auti 130		MO	
B 88 8 8		Talelle to Traises 7. M. 2222 W. North Are. Ba	Hone, P.	21216_	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Inte	proximate erval Between	
Enysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Karof Breast with metas kegs 5	2	set and Death	
Examiner		Due to (or as a consequence of):			
7. 4	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
execute an and rial-trans	Sequentially list conditions, if any, leading to b immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
O be existed the system of the	l <u>a</u>	d d			
ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physic should be detached for use as the benefit of the control of	Physician/Medi	IF FEMALE:			
ox 6 ox 6 auth cer	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery	.,	
Box he death of the attentiched for us	nysic	in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day	y Year	
rrds, P.O. I requires that the even signed by the	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco	use contribute to the ca	ause of death?	
ecords, le law requires e has been sign	1 Yes 2 No 3 Probably 4 Unknown				
Coor law re law be	Completed	24a. Was an autopsy	24b. Were autopsy f	findings available etion of cause of	
I Re		performed3. 1 □ Yes 2 ☑ N	death? lo 1 ☐ Yes 2 ☐		
26. Place of Death (Check on Hospital: 1 Yes 2 No Hospital: 27. Manner of Death 28. Detection in the property of t			A2 6	5	
of Physical of Phy		27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury		tospic C	
vision or attending offer death.	Certificate:	2 Accident Investigation M 1 Yes 2 No			
invision of or attending Phage detection of the funeral In by the funeral	Cert		nd Number or Rural Rou e)	te Number,	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
281. Location (Street and Number or Rural Route Number, City or Town, State) 282. Location (Street and Number or Rural Route Number, City or Town, State) 283. Location (Street and Number or Rural Route Number, City or Town, State) 284. Location (Street and Number or Rural Route Number, City or Town, State) 285. Location (Street and Number or Rural Route Number, City or Town, State) 286. Location (Street and Number or Rural Route Number, City or Town, State) 287. Location (Street and Number or Rural Route Number, City or Town, State) 288. Location (Street and Number or Rural Route Number, City or Town, State) 289. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)					
with Concord	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14383 29d. Date signed (Month, Day, Year)				
		20 Name and address of person who completed cause of death floor CO. Time District	146,20	# 7	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold C Stands Ford Joseph Richer Hospice Baltimore MD					
Stat Registra	te ar	31. Date filed (Month, Day, Year) 32. Régistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 Physician/ 1ดั 2011 9:00 A M HOWARD **JACKSON** JR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD ABERDEEN 203 SPESUTIA RD. 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 🛣 M 2 🗆 F 82 Director 220-22-5182 08-17-1928 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location Director Examiner must be notified 1 Yes 2 X No ABERDEEN HARFORD MD 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 23a U.S.A. 21001 203 SPESUTIA RD. 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. 1950–1952 Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) HEALTH NURSING ASSISTANT Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is meriany injury or other. 17. Father's Name (First, Middle, Last) ျ MARTHA QUOMOMY L. JACKSON SR. HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPESUTIA RD. ABERDEEN, MD 21001 CARLEEN JACKSON/DAUGHTER 203 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State ABERDEEN, MD GARDENS 07-16-2011 HARFORD MEM. 4 ☐ Donation 5 ☐ Other (Specify) e of Fune al Service Lice WILLIAM BROWN COMM. FUNERAL HOME-HARFORD P.A. 321 S. PHILADELPHIA BLVD. ABERDEEN, MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 1211 disease or condition Medical resulting in death) Examiner wars Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☑ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other (Specify)} \) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

DHMH 17 Rev 7/2009

24 hours

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

ur Chisapeake Dr

29d. Date signed (Month,

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per fh,g922,12/15/2011dhb Reg. NZ 1 - For State Registrar Amend Item 8 Reg. NZ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OHNSON 10:10AM ENA 20U 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ounty of Death **Examiner** PAROL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 3, 1 If Under 1 Year 6 Sex 9. Birthplace (State or Foreign Security Numbe 7. Age (In yrs. last birthday) Months Days 1 □ M 2 K F Yrs 1923 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits MD Funeral Director 1 ☐Yes 2 No Street 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Be Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 001 17. Father's Nar (First, Middle, Last) 18. Mother's Name (First, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town) ∉Type, Print) DAU Informant's Name/Relationship Zip Code 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date 20c. Location - City or Town, State Unit 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 Removal from State 5. ☐ Other (Specify) 22. Name and Address of Facility 5 21. Signature o eral Service Licep 3111 Mountain Rd fasadena eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. En er the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes ② No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burlal-tran Division of Vital Records, P.O. Box 68760 filled in by the

Physician

/Medical

Examiner

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

within 24 hours after death. To the Funeral Director: A completely

0	
Sta	te
Desista	

29d. Date signed (Month, Day, Year) 7200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NVQ. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 4 2011

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28a. Date of Injury (Month, Day, Year)

			For State Registrar	State of Marylan		rtificate of I		F	Reg. No	2011	22433
	Physici		1. Decedent's Name <i>(First, Middle, La</i> Fmil	Frederick		Jorio		2. Date of Dea Month July 1	ath Day	Year	3. Time of Death 12:45 a M
L.,	/Medio		4a. Facility Name (If not institution, given				Location of Death	oury 1		County of Dea	
, L			Riverview Nurs 5. Social Security Number 6.5	-	lact hirthday)	If Under 1 Year	Essex If Under 24 Hrs.	Doto of Pirtl			timore
	Funeral Director			7. Age (mys. 87		Months Days	Hours Min.	8. Date of Birtl (Month, Day October	y, Year)	923 Ma	thplace (State or Foreign ountry) aryland
	ryland show	_	10a. State 10b. County	imore 10c. Cit	y, Town or Lo	cation Dundall	-				10d. Inside City Limits
	he Ma 28a-f s	ecto		TIMOLE			<u> </u>			4110	1 ☐ Yes 2 ☒ No
	ath with t	Funeral Director	7323 Conley St	reet		10f. Zip Code	21224			zen of What Co USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modecal Examiner must be notified at ancoce.	þ	11. Marital Status 1 □ Never Married 2☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Ye ar or Dates:	ľ	Was Decedent of H If Yes, specify Cuba 1 □Yes 2🏋 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.
15-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Ki	nd of Business	/Industry
712	withir jiene.	omp	Elementary/Secondary (0-12) 11 years	College (1-4or 5+)	IITe.	DO NOT use retired Manage i	•			B.P. C	oil
and	ld be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last, Gabriel Jorio)			18. Mother's Name	(First, Middle,		Surname)	
Maryland	nd 2 shou alth and № 27 is mar		19a. Informant's Name/Relationship (,		ng Address (Street a					
Baltimore,	Pages 1 annount of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	nemoval from State		sition (Name of matory or other plac t Of Jesus		y 16,		cation - City or	Town, State Maryland
Balti	permit. Departr Importa any inju		21. Signature of Fune II Service Lice	/	22	2. Name and Address Connelly 7110 Soll			Dun	dalk, P	.A.
			23a. Part 1. Exter the disease, or com	plications that caused the death						dalk, M	Id. 21222 Approximate Interval Between
and the second	Physician	i i	shock or heart failure. List only Imme late Cause (Final disease or condition	one cause on each line.	0	~	jonys)	hathy			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		00				//
		e	Sequentially list conditions,	b. Due to or as a conse	ience of						
	cuted nd ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	c							
68760,	rificate be executed ig physician and as the burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequent	uence of):						
	E S E	Medical	IF FEMALE:	u							
O. Box	the death cerry the attendin	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	death 3	Ectopic pregnancy Other (specify)	/		2	23d. Date of de Month	livery Day Year
ດ, ກຸ	e law requires that the d has been signed by the e 2 should be detached	by Ph	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	nderlying cause give	en in Part I.	23e. Did to	bacco u	se contribute to	o the cause of death?
ord	require een sig	ted h	tanque te	thrune 1	/_	no-a		1 🗆 Y	es 2[] No 3 ☐ P	robably 4 Unknown
il Records,	The law a sate has b page 2 sh	Completed	Adnoba	Dema	Na	<u> </u>		24a. Was a autop: perfor 1 🗆 Yes	sy med? _	prior to death?	utopsy findings available completion of cause of
Vital	slcian; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death	n (Check only or	ne)		
0	g Physer this eral di	n: To	1 Yes 2 No 27. Mayner of Death	28a. Date of Injury	28b. Time of	28c. Injury	4 Nursing Ho	me 5 Resid			ecify)
	ending sath. or: Aftu	atio	Natural 5 Pending investigation		Injury	Work	r? Yes 2 □ No			•	
DIVISION	al or Attu s after de l Directo d in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow			ural Route Number,
:	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occuri	and due to the cred at the time, of	cause(s)	and manner a place, and due	is stated. e to the cause(s)
	vithi To th	M	29b. Signature and/title of certifier	D .		29c. License	8 78 4	-	29d. Dat	e signed (Moni	th, Day, Year)
			30. Name and address of person who	3BM. 709	BI	ASTER	N BL	-VD,		MP-	2/22/.
	Sta		31. Date filed (Month, Day, Year)	32. Radismar's Signal	ture	6.41					
	Registra	ar	JUL 1 4 2	UTT Cenus	p. A	POUCE					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical Nes DDIE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs **Director** rainia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MT TMORE 10g. Citizen of What Country? Street and Number 10f. Zip-Code 21 2 Funeral Was Decedent Ever in U.S. Armed Forces? ✓ Yes 2 ☐ No Mes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department OF Air Force 18. Mother's Name (First, Middle, Maider Surname) 17. Father's Name (First, Middle, Last) Be and Mental nariotte iamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Infor ent Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once, eraldin 1to.MD2/239 Wite 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 2011 3 Removal from State Donation 5 Other (Specify) Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or 23a, Part 1, Enter the disease shock, or heart failure. Immediate Cause (Final hysician hemorrhage Intracranial disease or condition #Medical resulting in death) Due to (or as a consequence of) Examiner Acute myelogenous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No be detached 9 Unknown P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 🗌 No 2 No 1 Yes certificate of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA မ Director: After this upletely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury Certification: I or Attending F after death. 5 Pending investigation (Month, Day Year) Division Injury 1 X Natural 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a the Hospital 29a. Certifier (check only 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ S D0070620

Registrar
DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER

Day, Year)

31. Date filed (Month,

ANAKRY

			For State of Maryland				nd M	, ,		n 1	221.25
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of			Reg. N20	11	22435	
	Physicia	in/	i. Decedent's Name (First, Middle, Last)					Date of Dea Month	th Day	Year	3. Time of Death
	Medic		Louis 4a. Facility Name (if not institution, give street and number)		King			July	11	2011	
	Examir /	ıer	Glen Burnie Health & Rehabilita	ation	4b. City, Town, Glen E		Death			ty of Death e Aru	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24	4 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign
н	Director		220-20-3581 1 M 2 D F 83	Yrs.	Months Days	Hours	Min.	OMenth, 294		West	Virginia
	d ow		Usual Residence of Decedent 10a. State 10b. County 10c. City		<u> </u>						
	ırylan •-f sh ied a	Director		, Town or Lo n Burn						1	10d. Inside City Limits 1 ☐ Yes 2 1 No
	or 28s	Dire	10e. Street and Number		10f. Zip Code				10. 0"		
	with th	eral	8009 Shelton Ave.		21060				10g. Citizen of USA	what Cour	ntry?
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S		Was Decedent of	Hispanic Origin	n? (Spec	cify Yes or No-		ace - Americ	can Indian.
36	after de il", or if xamine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 M Yes 2 No If Yes, Give	1	f Yes, specify Cub I ☐ Yes 2 🔀 N	an, Mexican, F	Puerto F	Rican, etc.)		ack, White,	
21215-0036	natura ical E	Completed	15. Decedent's Education		lent's Usual Occu				16b. Kind of I		dianto
215	n 72 l an "r	m d	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	kind of work done NOT use retired	durina most o	of workin	ng i	100. Kind of I	susiness in	austry
2	withi giene ver th t, the		7th / /		mechanic				autom	otive	
pu	e filed stal Hy sd ott	To Be	17. Father's Name (First, Middle, Last) Frank King			1		(First, Middle, N			
ry ls	d Mer mark matic						lia			csis	
, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Helen King spouse	19b. Mailin 800	g Address (Street 9 Shelto	and Number on Ave.	or Rural Gle	Route Number, n Burni	City or Town, .e MD 2	State, Zip 0 1060	Code)
Baltimore,	ge 1 a nt of H : If ite or oth		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ce	emetery, cren	sition (Name of natory or other pla			ate	20c. Location	•	
Ιţμ	nit. Parantmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re if Funeral Service Livensee		matory 1			/2011			aryland
Ba	permit Depar Impor any in		I had to		. Name and Addr	ountair	n Ro	ad Pasa	dena Mi	Home D 211	P.A. 22
			23a. Part 1. Enter the disease, or cominity ations that caused the death shock, or heart failure. List only q e cause on each line.	. Do not ente	er the mode of dyi	ng, such as ca	ırdiac or	respiratory arre	est,		Approximate Interval Between
	Anysician/ Medical	3	Immediate Cause (Final disease or condition resulting in death)		DISE	EASE				1/4	Onset and Death
	Examiner		Due to (or as a conseque	nce of):							
	- ÷	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence to the Underlying	ence of):							
	icate be executed g physician and s the burial-transit	хап	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of the	anno off:							
_	be exision purial	dical	but to (or as a conseque	ince oij.							
760	icate phys s the	ധ	d								
89	certif anding use a	N/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan	су					23d. D	ate of delive	erv
P.O. Box 687	tt the death certifica I by the attending p stached for use as t	sicia	in the past 12 months? 1	death 3 L eath 5 L	Other (specify)	cy				onth	Day Year
0	it the	Phy	a 🗆 Olikilowii					1			
ν, σ,	lor Attending Physician: The law requires that the death certificate be executed after death. Director. After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	Part II. Other significant conditions contributing to death but not result			iven in Part I.			es 2 No		ne cause of death?
ğ	requii been should	etec	PARKINBON'S DISEASE	75							
ecc	sician: The law is certificate has birector, page 2 s	dmo	TAKEINSON S OBONS	•				24a. Was ar autops perforr	Sy		osy findings available mpletion of cause of
<u> </u>	in: Th ifficate or, pa		25. Was case referred to medical		26 5	loop of Dooth	(Charles	1 Yes			2 No
Ĭ	ysicie is cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	B/Outpatien	Ott	lace of Death (ne 5 🗆 Reside	2 🗆 00	(0 :(
of	ng Phy ter thi		27. Manner of Death 28a, Date of injury 2	28b. Time of	28c. Inju	y at	-	Bd. Describe ho)
o	endin sath. or: Aff he fur	fica	2 Accident Investigation	injury	M 1 🗆	k?]Yes 2 □ No	0				
Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28	8f. Location (Str City or Town		er or Rural	Route Number,
	pital ours a eral C		29a. Certifier 1 Certifying Physician: To the best of my knowled	des test	1.10.0						
:	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a 3 Certifying Nurse Practioner: To the best of my knowled to the basis of examination a construction of the basis of examination and the basis of	and/or investi	gation, in my opini	on, death occur	rred at the	ne time date and	d place, and du	ie to the call	ise(s) and manner stated
	To th Cong	~	29b. Signature and title of certifier		29c. Licens	e number			9d. Date signe	ed (Month, E	Day, Year)
	W		1) harmono, M			1775	3		7/	13/2	1100
	21.8m		30. Name and address of person who completed cause of death (Item 2 K · S · D HARM ASENA, M.D.	3a) (Type, Pr	PATES	97	PA	HTIME	RE 1	40	21225'
	Stat	е	31. Date filed (Month, Day, Year) JUL 1 4 2011 Server 32. Registrar's Signature		TUTCE	37.		-, , , , ,	- , 0	-10	
	Registra	r	JUL 1 4 2011 Kenne Vo. 1900								

			1 - State of Maryland Dep 20b,c per fh,g91/, Cel	artment of Health and N 07/14/2011dhb rtificate of Death	Mental Hygie	ne N 2011	22436
ı	Physicia		1. Decedent's Name (First, Middle, Last) kenneth Lindsay Sr.		2. Date of Death Month	Day Year	3. Time of Death 16: 24 PM
of the sample	Medi Examii		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	7	4c. County of Death	10.27
and and	Funeral	F	University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore, MD If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	VA 9. Birth	place (State or Foreign
	Director		214-84-5623 1 M 2 F 7. Age (In yrs. last birthday) Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, Yea	1962 Cour	MD
	yland •f show ed at	ctor	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	the Mar or 28a e notifi	Director	md Unne Orundel Pasader	10f. Zip Code	10a.	. Citizen of What Cou	1 Yes 2 No
	th with ms 23a must b	Funeral	8349 Catherine Ave.	21122	US		
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto Pes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B	
Maryland 21215-0036	J within 72 ho ygiene. her than "na ht, the Medic	e Completed by	Elementary/Seconday (0-12) College (1-4 or 5+) (Give life, D	lent's Usual Occupation kind of work done during most of worki ONOT use retired) DIEO	ng	b. Kind of Business In	dustry
ryland	uld be filed I Mental H marked ott natic even	To B	Rayfield Lindsay	Mary Ho	e (First, Middle, Maid	-	
, Ma	nd 2 sho ealth an m 27 is i		19a. Informant's Name/Relationship (Type, Print) Raren Lindson - 615ter 9345	ng Address (Street and Number or Rura Catherine Ave	Route Number, City	or Town, State, Zip (Code) 21122
altimore,	Page 1 ar tment of He tant: If iter jury or oth		4 Donation 5 Other (Specify)		Date 20c	Location - City or To atonsvill WASVILL	own, State MD
Bal	Depar Impor any in		21. Signature of uneral Service License	Name and Address of Facility NYP MOUTH FIH 270 F		ass Balto. r	
			23a. Parv . Prity the disease, or complications that caused the death. Do not ente shock or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of):				Onset and Death
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	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Renal Failure c. Renal Failure				
0	ate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
8760	tificate ing phys as the	Medi	d				
P.O. Box 687	he death certificate be executed y the attending physician and iched for use as the burial-transi	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy in the past 12 months? 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
	Attending Physician: The law requires that the de rotation at oath. ector. After this certificate has been signed by the by the funeral director, page 2 should be detached	b	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		o use contribute to the	e cause of death?
Division of Vital Records,	sician: The law re s certificate has be lirector, page 2 sh	Completed			24a, Was an autopsy performed?	prior to coi death?	osy findings available inpletion of cause of 2 140
XIII	Physician this certifi al director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Check		6 ☐ Other (Specify)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	8d. Describe how inj		·
ivisio	or Attending after death. Director; After din by the further	Certificate:	2 Accident 3 Suicide 4 Homicide Investigation Could not be determined Could not be building, etc. (Specify) Could not	M 1 ☐ Yes 2 ☐ No et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural ate)	Route Number,
_	Io the Hospital or At within 24 hours after of To the Funeral Direct completed filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investionly one) 3 Certifying Nurse Practioner: To the best of my knowledge, death or construction of the basis of examination and/or investigation.	gation, in my opinion, death occurred at t	the time date and nla	ce and due to the cal	se(s) and manner stated
	with Coat	-	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, L	
			30. Name and address of person who completed cause of death (item 23a) (Type, Pr	PES 000			
	Stat	e l	31 Date filed (Month Day Year) 29 Decistraria Cianatura	street Bultimore, n	NU 21202		
	Registra	_	JUL 1 4 2011 Line A. Law	W.			

JULY 10, 2011 5:35 a.m.

ELEANOR LOCKETT
n of Vital Records, P.O. Box 6876

			- For A	Plea amend	ase Type o #19a Per State m 2 per	r Prin ANA of Ma	tin Blac BD G91 ryland 4	gk ly Dena	Helible	ink of H	រក៏ns ealth	ure A	All Copie Mental H	es Ar ygien	e Leg i	ible.	1	
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ı	Physicia		1. Decedent's Nam Eleanor									_	2. Date of D Month	eath 0	7/10/2	2011 011	3. Time of 1	Death A M
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-	Funeral	г	Stella I 5. Social Security N		6. Sex	7. Age	(In yrs. last birt	hday)) If Under 1 Year If Under 24 Hrs. 8, Date of Birth						Т	timo 9. Birth	olace (State or	Foreign
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	yland -f shov ed at	ctor	10a. State	10b. County			10c, City, Towr			-							0d. Inside City	
	the Mar or 28a e notifi	Director	MD 10e, Street and Nur	mber			Balt	timo	nre 10f. Zip C	ode				10a. C	Citizen of W	hat Cour	1 XYes	2 L No
	th with ns 23a must b	Funeral		lgate .						222					USA			
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		14 1/ 0	Forces? s 2 N live		J1	Vas Deceden Yes, specify	Cuban	, Mexicar	, Puerto	ecify Yes or No Rican, etc.))-		- Americ k, White, whi t		
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Maryland	uld be filed Mental H narked ot natic ever	To B	17. Father's Name (Spear									e (First, Middle Lecheka		n Surname)			
e, Mai	ie 1 and 2 sho t of Health and If item 27 is r or other traun	8	19a. Informant's Na Patrici 20a. Method of Disp	.a McCo	19(Type, Print) 11 – daus	ghter		630	48th	St;		Ltimo	ore, Ma	ry1a	and 2	1224		
Baltimore,	t. Page tment c tant: If jury or		1 ☐ Burial 2 4 🛛 Donation	☐ Cremation 5 ☐ Other (S		1	. 20b. Place of cemeter	ry, crem	atory or othe	er place)			Date		Location -		own, State	
Ba	Depar Impor any ir		21. Signature of Eur	niel	Naylor	1		22					ate Ana St; Ba				21201	
	Physician/		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or conditio	rt failure. List o Final	only one cause on e	t caused the cach line.		ot ente	r the mode o	of dying,	such as	cardiac d	r respiratory a	ırrest,			Approximate Interval Betw Onset and De	reen
and showing	Medical Examiner		resulting in death)				consequence of	of):										
	ted nsit	Examiner	Sequentially list coif any, leading to imcause. Enter Under	mediate rlying	b. Due to	o (or as a c	consequence o	of):						-				
0	be executed sician and burial-transit	l= I	that initiated events resulting in death) I		c. Due to	o (or as a c	consequence o	of):										
9289	rtificate ing phy e as the	/Medi	IF FEMALE:															
	es that the death certificate be igned by the attending physici be detached for use as the bu	Physician/Medica	23b. Was decedent in the past 12 r 1 Yes 2 Unknown	nonths?		e Birth 2 gnant at ti	pregnancy Fetal death ime of death		Ectopic pred Other (speci						23d, Date Mon		ery Day Ye	ear
	v requires that the been signed by the should be detach	þ	Part II. Other signifi	icant condition	ns contributing to	death but	not resulting in	n the ur	nderlying cau	ise giver	n in Part I					_	ne cause of dea	
of Vital Records,	The lay ate has page 2	Completed											24a. Was auto peri 1 Yes	opsy ormed?	pr de	ere autorior to co eath?	osy findings av mpletion of car 2 No	railable use of
Vital	ysician is certif director	To Be	25. Was case referre examiner? 1 Yes 2	_	Hospital:] Inpatient	t 2 🗆 ER/Out	tnatient		26. Plac Other:			only one)	idanna	6 M Other	/Spacific	HOSPI	CE
on of	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		27. Manner of Death 1 X Natural 2 Accident	5 Pendin	g 28a. Date (Moi		28b. T			Injury a work? 1 \(\subseteq \text{ Ye}			28d. Describe				HUSET	OE
	tal or Att s after d al Direct		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could i determ	ined 28e. Plac	e of Injury ling, etc. (- At home, far Spec <i>ify)</i>	m, stre	et, factory, of	ffice			28f. Location City or To			or Rural	Route Numbe	r,
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check 2	Medical E	Physician: To the xaminer: On the ba Nurse Practioner	isis of exar	mination and/or	rinvesti	gation, in my	opinion.	death oc	curred at	the time date	and plac	e and due	to the car	ise(s) and mani	ner stated.
	To With		29b. Signature and t	14/1	Nesch.	NP			RI	cense n 49	19 2	2		29d. Da	ate signed	(Month, i	Day, Year)	
_			30. Name and addre	JONES,			th (Item 23a) (T ULANEY			D.	TIMO	NIUM	, MD 2	1093	3			
	Stat Registra		31. Date filed (Month	1 4 2	8 2. Ⅰ		Signature	are										
	100		G		1000		-											

11-05156 Jonathan Levin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certifi	icate of	Death		Re	eg. No.	
Physicia Modical Exami		1. Decedent's Name (First, Midd						Date of Deal Month	Day Year	3. Time of Death 2017 hrs
enical Exami	ner	JONATHAN 4a. Facility Name (if not institution	DEV		14	b. City, Town, or	Location of F	July 10, 20	14c. County of De	
		6006 Park Heights Av	-	,		Baltimore			N/A	
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last t	oirthday)	If Under 1 Yea			th(MM/DD/YYYY) 9.	Birthplace (State or reign
Director		21464-3790	1XM 2 F	57	Yrs.	Months Day	s Hours	Min. 04/28	/1954	Country) MD
yns		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Locatio	on				10d. Inside City Limits
₽ . H			N/A		ALTIM					1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	-\u00e4	<u>_</u>	ALITIN	10f. Zip Code		11	0g. Citizen of What C	ountry?
death with the Maryland or items 23s or 28s-f sho must be notified at once.		3406 PARKING	GTON AVENUE			21	.215		USA	
h with	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Deceden					? (Specify Yes or No- uerto Rican, etc.)	- 14. Race - An White, etc	nerican Indian, Black,
er deat	핊			X No				dorto (tibuli, oto.)		WHITE
11215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner	ğ	15. Decedent's Education (Spe	or Dates:	mpleted) 16		Yes 2. No s Usual Occupa		d of work done	Specify: 16b. Kind of Busine	
72 hor	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo	st of working life	. DO NOT use	e retired)		·
vithin ene.	直	6			SALES	SPERSON			SALES	
filed THyging of the		17. Father's Name (First, Middle	, Last)					Name (First, Middle, N	Maiden Surname)	
ID 21215-003 should be filed within and Mental Hygiene. T is marked other the	To Be	SAMUEL 19a, Informant's Name/Relations	ship (Type, Print)	LEVI		Address (Stree	DORC	THY r or Rural Route Num	ber. City or Town. St	UNKNOWN ate. Zip Code)
, MD 21215-0036 and 2 should be filed within 's teath and Mental Hygiene, tem 27 is marked other than traumatic event, the Medici		AMELIA LEVIN	N/WIFE					MENUE, BAL	-	
Fe, I and F Healt Fitem	Ì	20a. Method of Disposition 1 X Burial 2 Cremation			e of Disposit	ion (Name of cer	metery,	Date	20c. Location - City	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ab. injury or other traumatic event, the Medical Examiner must be notified at once	H	4 Donation 5 Other S		BE VE	SHEAR	COB ANSF CEMETER	{Υ C	07/11/2011	BALTI	MORE, MD
Salt ermit Separtu mportu		2 . ignature of Funeral Servic	1		22. Na	ime and Address	of Facility	SOL LEVIN	SON & BRO	S., INC.
Physician	-	23a. Part I. Enter the disease, or	compliations that caused	the death. Do	not enter the	00 REIST mode of dving.	ERSTON such as card	VN ROAD, P	IKESVILLE	MD 21208 Approximate Interval
/Medical		failure. List only one cause	on ea Mine.					,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	equence of):						
		Sequentially list conditions,	b.							-
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence or):						
ed nsit	Exar	events resulting in death) Last	Due to (or as a cons	equence of):						
760, cate be executed physician and the burial - transit		UNPENDED	dAMENDED							
760, icate be ext physician the burial	Medical	IF FEMALE:	23c. If yes, outco	me of pregnanc	sy .				23d. Date of deliv	ery
	- 1	23b. Was decedent pregnant in the past 12 months?	. Live birat	time of death	_ =		Ectopic pr	egnancy	Month	Day Year
Box 68 t death certif the attending ed for use as	Physician	1 Yes 2 No 9 Uni	known 9 Unknown	time of death	5 Othe	er (Specify)			1	
Records, P.O. Box The law requires that the death cate has been signed by the arte page 2 should be detached for t		Part II. Other significant condit	tions contributing to deat	h but not result	ing in the un	derlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
B, P.O.	ğ D							1 Yes	2 ✓ No 3 ☐ P	robably 4 Unknown
cords, Plaw requires that has been sign 2 should be contact.	Completed							24a. Was a autops	sy prior t	autopsy findings available ocompletion of cause of
Rec The la	틹							1 Yes 2		? Yes 2 No
on of Vital Receding Physician: The sath. or: After this certificate the funeral director, page	8	25. Was case referred to medical examiner?	Hospital:				of Death (Ch	<u> </u>		
Physical Control of Victor Control of Victor Control of Victor Control of Victor Officer Control	와	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	iry 28b	Outpatient Time of Inj		y at Work?		Residence 6 🗸 Ot	ner: Scene
on of sading Pl	15	1 Natural 5 Pend	Jul 10, 2011	^{'ear)} 20	11 hrs	. 1 _	es 2 ✓ No	Subject hand		
Division of Vital Records, tal or Attending Physician: The law requirers after death. 1 Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	E		stigation 28e. Place of Ir	njury - At home,	farm, street	factory, office b	uilding, etc.			Rural Route Number, City
Dipital of the sales at Illed	Certification:	4 Homicide deter	rmined (Specify) Gre	oup Home				6006 Park Hei	ate) ghts Avenue, Balti	more, MD
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		29a. Certifier 1 Certifying Pt (Check only one) Medical Example 1	hysician: To the best of m miner:On the basis of exa	y knowledge, d	eath occurre	ed at the time, da	te and place,	and due to the cause	e(s) and manner as s	tated.
To t with To t	BL	29b. Signature and title of certifie	and manner stated.		Jongana	29c. License			29d. Date signed (
		Dat Ara	~ Oc	00.0		O.C.1			July 11, 2011	, 22,, . 33.,
	F	30. Name and address of person	who completed cause of c	leath (Item 23a)	- MS					
		Patricia Aronica-Pollal	k MD. Assistant N			00 W. Baltin	nore Stree	t, Baltimore, MD	21223	
Sta Regist	_	31. Date filed (Month, Day Year)	2011 32 Aegistra	r's Signature	har					
DHMH 17 Rev 1/20	_	002 2 1	LUII Klasus	- 1	RIGINAL					
				J	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22439 Certificate of Death 2. Date of Death cedent's Name (First, Middle, Last) Physician/ latherson Medical street and number County of Death **Examiner** Town, or Location of Death towar olumbia 8 Date of Birth (Month, Da 9. Birthplace State or Foreign Country) last birthday) If Under 24 Hrs **Funeral** 1 □ M 2 🔽 F Hours Min Months Director 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 Yes 2 No mbia 10f. Zip Code 10g. Citizen of What Country? ŏ must be 23a . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ ŏ 1 Dever Married 2 Married Baltimore, Maryland 21215-0036 BlaIf Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired than Elementary/Seconday (0-12) College (1-4 or 5+) the ith and Mental Hygien 27 is marked other tl r traumatic event, the Be 17. Father's Name (First, Middle, Last) ပ္ permit. Page 1 and 2 should be Department of Health and Ments Inorntor (Type, Print) (Daughter ant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10101 Governor Warfield Pkwy Columbia, fitem 27 i 50N 20a. Method of Disposition 20b. Place of Disposition (Name of City or Town, State ± 5 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. 4 Donation 5 Other (Specify) 21. Six Ture of Funeral Pervice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SMAU CELL LILNA CANCER MONTHS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and the burial-tran or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY 1 X Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbb{X}\) Other (Specify, 1 Yes 2 X No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending
Investigation 1 Natural within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes Accident 2 🗌 No Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64395 JULY 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6336 CEDAR LANE COLUMBIA, MD 21044 DOBERMAN, MD DANIEUE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year ALMA IRENE MCNEELY JULY 12, 2011 1:13 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BELAIR Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Sex 1 M 2 XX 8. Date of Birth Birthplace (State or Foreign Country) Months Days SEPT 24,1924 234.62.7910 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits HARFORD **EDGEWOOD** 1 Yes XX No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 SEQUOIA DR. 21040 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Race - Anno... Black, White, etc. WHITE 1 Never Married 2 Married 1 Yes 2XX No If Yes, Give Year or Dates. 1 Tes 2 No Specify: 3xx Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ESTEL JONES** RUBY CRANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

506 SEQUOIA DR. EDGEWOOD, MD 21040

JULY 20, 2011

20c. Location - City or Town, State

OAK RIDGE

Ph_sician/ Medical

Department of Health ar Important: If item 27 is any injury or other trauonce.

Physician/

Medical

10a. State

MD

ELEANOR ANN WILLIAMS

. Sign : Funeral Service Lic

4 Donation 5 Other (Specify)

1 XX Burial 2 Cremation 3 XX Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20a. Method of Disposition

Examiner

Funeral

Director

or 28a-f show notified at

27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be

and Mental Hygiene. is marked other than "natural", or

Baltimore, Maryland 21215-0036

Neely, Alma Box 68760 Esp

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Records,

Division of Vital

To the Hospital or Attending Physician:

within 24 hours a To the Funeral C

Director

Funeral

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Completed

Be

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Examiner

Certificate: To Be Completed by Physician/Medical Examine

Medical

31. Date filed (Month, Day, Year)

JUL 1 4 2011

21. Sign 1 Funeral Service Lio rise K CRECORY FINK	M01148	22. Name and Address of Facility FINK FUNERAL HOME, F 426 CRAIN HWY SW CLE	P.A. t/a MARYLAN EN BURNIE, MD 21	ND MORTUARY	SUPPORT
23a. Part 1. Enter the disease or cond shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		enter the mode of dying, such as care			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or illipiny that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant conditions con	arthritis	ne underlying cause given in Part I.			the cause of death?
Rectal ca	rcinoma		24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?		26. Place of Death (C			
1 Tes 2 To	ospital: 1 Pinpatient 2 ER/Outpa	Other	g Home 5 Residence	2 0 0 0	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injur	e of 28c. Injury at	28d. Describe how inju		<u> </u>
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Star	and Number or Rui te)	al Route Number,
i check z in inedical examine	cian: To the best of my knowledge, dea er: On the basis of examination and/or in Practioner: To the best of my knowledge	restigation in my opinion death occurr	ed at the time date and place	o and due to the c	- t-t- variation
29b. Signature 3 hd title Pertifier hal Coloni k	lul	29c. License number D 6 3 4 2 0	29d. D	late signed (Month	, Day, Year)

500 upper chesageake Dr. Bel Air, MD 21014

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK RIDGE MEMORIAL PARK

State

Registrar

the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Sa

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of ceglifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 3, 2011 30. Name and address of p rson who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar' Signatur selle

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22442 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 Day 20// Physician/ RUBY MOODY _Month 4:13 JULY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Care Center Baltimore Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 219-30-068 Months Hours (Month, Day, Year, **Director** Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 □ No NIA HMore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 onway 21 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 NO Baltimore, Maryland 21215-0036 1 Yes 2 340 Specify: If Yes, Give Year or Dates Specify: 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Unemployment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ rockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 6 ☐ Other (Specify) 21 Sin ature 1 February Service Licens well ut Heig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrhythmia ⊸h, iiin disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner minutes failure Diratory Gaquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ears Small lun Non signed by the attending physician and d be detached for use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by anemia 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Date of injury
(Month, Day, Year) 28b. Time of injury
28c. မ After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (28c. Injury at work? 1 Yes 2 No 27. Manner of Death Certificate: 28d. Describe how injury occurred i Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 8 04383 weenouph mo

State Registrar

DHMH 17 Rev 7/2009

Bullimore

Hopkins Jay 19100 circle

NO 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505

32. Registrar's Signature

Breenough II MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jeiei Wici addei	•	1- For State Registrar	state of Maryland		rificate of D			201	22443
Physici		Decedent's Name (First, Michael Control of the				-	2. Date of Dea Month	Reg. No. ath Day Year	3. Time of Death
Medical Exami	iner	4a. Facility Name (if not institu	Kac e.c.v.	M/C	infact de	City, Town, or Location	July 10, 2		0310 hrs
		Johns Hopkins Hosp		.,		Baltimore	ro, Bodan	To. Southly of Boo	
Funeral		5. Social Security Number		ge (In yrs. las	**	f Under 1 Year If Und Months Days Hour		rth (MM/DD/YYYY) 9. B	eign
Director		220-23-2456	1 M 2 F		22 Yrs.	violitis Days Hou	2/-1	3-1789 Fore	country) MARY IN FIRE
Amy		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, T	own or Location				10d. Inside City Limits
and [sbow nce,	ō	Md			14.14	wore			1 Yes 2 No
ne Maryland or 28a-f show fied at once,	Director	10e. Street and Number	. 0	_	10	of. Zip Code	1	10g. Citizen of What Co	
9, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	al D	3124 BRE	tan AWE	t Ever in II S	13 Was D	21213	igin? (Specify Yes or No	U517	
leath w	Funeral	1 Never Married 2	Married Armed Forces			specify Cuban, Mexical		White, etc.	erican Indian, Black,
after or ral", o	by F		livorced If Yes, Give Year or Dates:		1 Ye			Specify: (1).	
2 hours "natu	ted	 Decedent's Education (Sp Elementary/Secondary (0-12 		·		Jsual Occupation (Give of working life, DO NO		16b. Kind of Business	/Industry
036 ithin 7. ne.	Completed	93	,	· 1	utan			vin	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	S	17. Father's Name (First, Middl					er's Name (First, Middle, I		
212' uld be: Mental marke	To Be	BERNAUL 19a. Informant's Name/Relation	Nº 40.dder	, SA	-		Mer or Rural Route Num	ackey	re Zin Code)
MD 12 sho 12 sho th and 27 is		LORENA M	ackey mon	A C Paris		PORSUCL			-,,,
Baltimore, MD 21215-00; pemit. Pages I and 2 should be filed with Department of Health and Mental Hygiere Important: If item 27 is marked other tinjury or other traumatic event, the Mes		20a. Method of Disposition 1 Marial 2 Cremation	on 3 Removal from S	cre	ace of Disposition	(Name of cemetery,	Date	20c. Location - City o	
timent creations		4 Dopation 5 Other	Specify:	MIT	Zion (emodery	7/23/2011	11-04/40 VI	Chapel to C.
Bal permi Depar Impo		21. Signature of Funeral Service	e Licensee		22. Name	e and Address of Facili	Muller's 11	netto politan	Chapel 4.C.
Physician		23a. Part I. Enter the disease, of failure. List only one caus		the death. D				est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a. Gunshot Woun)				Death
		Sequentially list conditions,	Due to (or es a cons b.	sequence of):					
	iner	if any, leading to immediate cause. Enter Underlying Caus-	Due to (or as a cons	equence of):			-		
. 184 - =	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					0 1
xecuted n and l-transit	la H	- LINDENDED	d.		. =				-
ox 68760, ath certificate be ex attending physician or use as the burial.	Medical	UNPENDED IF FEMALE:	AMENDED 20D, I	er Fh	g917, 7	/29/11 TT		23d. Date of deliver	
687(ertifica ding pl	an/	23b. Was decedent pregnant in past 12 months?	the 1 Live birth	, ,	2 Fetal d	eath 3 Ectopi	ic pregnancy		Day Year
30x death o	Physician/	1 Yes 2 No 9 U	4 Pregnant a	t time of deatr	1 5 Other	(Specify)			
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burjal - trans		Part il. Other significant cond	itions contributing to deal	h but not resu	ulting in the under	rlying cause given in Pa	art I. 23e. Did to	bacco use contribute to	the cause of death?
S, P	ed by							2 ✓ No 3 Pro	
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed						24a. Was a autop		utopsy findings available completion of cause of
Rec: The liftcate		25 Manager referred to medical				00 Pt	1 ✓ Yes	2 No 1 ✓ Y	es 2 No
Vital F ysician: nis certifi director,	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	11	ent 2 🗸 EF	R/Outpatient 3	26.Place of Death DOA Other		Residence 6 Othe	er:
ion of Vital trending Physician: teath. tor: After this certifi the funeral director,	<u>':</u>	27. Manner of Death	28a. Date of Injudical Jul 10, 2011		8b. Time of Injury	28c. Injury at Work	k? 28d. Describe h	now injury occurred	
Sion Attendideath.	catio		estigation		236 hrs	1 Yes 2 🗸			
Division pital or Attendi ours after death. ceral Director: A	Certification	dete	ald not be 28e. Place of Ir ermined (Specify) Lo		e, farm, street, fa	ctory, office building, et		Street and Number or Ri tate) Iorton Court , Baltimo	ural Route Number, City
Hospi 24 hou Funer	_	29a Certifier	Physician: To the best of m		death occurred a	at the time, date and pla			
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 2 Medical Ex	aminer: On the basis of exa and manner stated.			in my opinion, death oc		and place, and due to the	ne cause(s)
	≥	29b. Signature and title of certifi	er / SAI			29c. License number O.C.M.E.		29d. Date signed (Mo	nth, Day, Year)
2	-	30. Name and address of person	who completed cause of a	leath (Item 23	Ba)	O.O.IVI.E.		July 10, 2011	
		Melissa Brassell, MD	the state of the s			altimore Street, B	altimore, MD 2122	23	
		31. Date filed (Month, Day, Year,	32. Registra	r's Signature	del		 		
Regist	œ.	4UL + 4 ZUII	(Russia C		Ver				

			For State of Maryland / Depa		Mental Hygiene	
			Registrar 1. Decedent's Name (First, Middle, Last)	tificate of Death	Reg. No.	3. Time of Death
	Physicia Medic		Joseph A. Murphy, Jr.			11:20 P M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	
44	1	П	Mays Chapel Ridge	Timonium		1timore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth NOV. 1, 1928 M	9. Birthplace (State or Foreign Country) Iary Land
			Usual Residence of Decedent		1, 1920	al y land
	ryland -f sho ied at	ctor	10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits
	ne Mau or 28a notifi	Dire	Md. Baltimore	Timonium 10f. Zip Code	10g. Citizen of Wh	1 Yes 2 X No
	with the 23a c	Funeral Director	12261 Roundwood Road Unit#306	21093	US	
	items	Fun		as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	- American Indian,
9	after (II", or xamir	d by	1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ No	Yes 2 No Specify:	Specify:	White, etc.
3	nours natura ical E	Completed	15. Decedent's Education 16a. Decede	ent's Usual Occupation	16b. Kind of Busi	White
212	in 72 e. nan "r	duc	(Specify only highest grade completed) (Give ki Elementary/Seconday (0-12) College (1-4 or 5+)	nd of work done during most of worki NOT use retired)	ing	
7	d with lygien ther tl nt, the	Be C		Newspaper		ertising
anc	should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To E	Joseph A. Murphy, Sr.	18. Mother's Name	e (First, Middle, Maiden Surname) 7 I. Chaffman	
arz	2 should be tth and Ment 27 is marke traumatic e			Address (Street and Number or Rura		te, Zip Code)
Σ		3	<i>x</i>		noenix, Maryland	
Baltimore, Maryland 21215-0036	2 = 0 = 1		TA Abuna 2 - Oremation 3 - Nemovalitom State	atory or other place)	İ	City or Town, State
E E				lley Mem. Grd. 7/		
g	permit. Departr Import. any inju			Name and Address of Facility Ruc 050 York Road To	ck lowson funera owson, Maryland	, ,
			23a. Part 1. Enter the disease, or cop plications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate
J	Physician	0.3	Immediate Cause (Final disease or condition	nsufficiency		Interval Between Onset and Death
	Medical Examiner		Due to (or as a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			Seven years
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury			
	execuian an	EX	that initiated events c. Due to (or as a consequence of):			
20	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d			
280	certific nding I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date	of delivery
POX	Jeath (e atter	sicia	in the past 12 months? 1 Yes 2 No 1 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Mont	
5.	t the c by th	Phys	9 Unknown	de l'Anna de la Contra de Parti.		
ν., 7,	res tha signec	by	Part II. Other significant conditions contributing to death but not resulting in the un Hypertersion	derlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
ğ	been should	lete				ere autopsy findings available
Records,	he law te has age 2	Completed			autopsy pri- performed? de	or to completion of cause of ath? ☐ Yes 2 ☐ No
<u></u>	ian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check		□ Yes 2 □ No
VItal	hysic this ce al dire	မ	1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		me 5 Residence 6 Other	
n OI	ding I th. After funer	cate	27. Manner of Death 1 № Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
DIVISION	Atten er dea ector; by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree		28f. Location (Street and Number	or Rural Route Number,
2	ital or urs after al Dir led in		building, etc. (Specify)	,	City or Town, State)	
).	Hosp 24 hou Funer	Medical	29a. Certifier (Check 2 Medical Examiner: On the bast of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred at	the time, date and place, and due to	o the cause(s) and manner stated.
	To the within Fo the somple	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, de 29b. Signatura and title of certifier	ath occurred at the time, date and place 29c. License number	e, and due to the cause(s) and mann 29d. Date signed (i	
	1		Ser mendina (m. b. W)	D53517	July 1	
7	,ot 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	nt\	7	
O			ARNEL MENDOZA AGILE MD 301 SAINT PAUL PLA 31. Date filed (Month, Day, Year)	ace Baltimore Ma	IRYLAND 2120Z	
	Stat Registra	_	III 142011 Lane D. bare	ALE BALTIMORE MA		
		_	COLUMN TO THE PARTY OF THE PART			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Daniel Moore, Jr. Day 201 Year July 9:20 PM 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** c. County of Death Baltimore 4b. City, Town, or Location of Death Greater Baltimore Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ▼M 2 □ F Hours 212-30-5720 **Director** 78 4/10/1933 Tennessee Usual Residence of Decedent show 10a. State 10b. County at 10c, City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a Maryland Baltimore Baltimore 1 ☐ Yes 2🌠 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 8513 Kavanagh Road 21222 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Completed 3 ₩ Widowed 4 Divorced Specify. Navy White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Driver Linen Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Smith Daniel Moore Della Sue Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Cynthia A. Jolley-D'Alfonso</u> 11 East Pennsylvania Ave. Stewartstown, Pa. 17363 Dtr. Baltimore, 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Cem. 7/14/2011 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Owings Mills, Md. Signature Juner Juner Li 22. Name and Address of Facility 1050 York Rd. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the arsease of shock, or heart failure. Usy complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner BOK Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav 1 Yes 2 L 9 Unknown 2 No sate has been signed by the spage 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillahon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy autopo, performed: Vas 2 No certificate 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \square Yes 2 No Certificate: To Other: 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

Registrar

State

fonth, Day, Year

4 2011

Marks, Katherine 7/11/11 536AM Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

		_ For	State of M		d / Depa	artment of H	lealth and	•		gible.	
		1 - State Registrar 1. Decedent's Name (First, Middle	a / ast)		Cer	tificate of D	Death		Reg. N2		22446
Physicia Medic		Katherine V.	Marks					2. Date of De Month July 1	1, ^{Day}	Year	3. Time of Death 5:26 A M
Examir	ner	4a. Facility Name (if not institution Oakcrest Care				4b. City, Town, or Parkvil		ath		y of Death timore	
Funeral Director		5. Social Security Number 256-18-4023	6. Sex 7. Ag	e (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th	9 Birthn	lace (State or Foreign try) land
3 1	Ž	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	eation		9/24/_	910		Od. Inside City Limits
Marylar 28a-f s otified	irecto	Maryland Balti	more		rkvill						1 Yes 2 X No
s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	10e. Street and Number 8820 Walther	Rlyd Ant 42	10		10f. Zip Code 21234			10g. Citizen of U.S.A.	What Coun	try?
r death ir items iner m	y Fun	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent 8 Armed Forces?	er in U.S		Vas Decedent of His Yes, specify Cubar			14. Ra	ce - America ack, White, e	
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	ted by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates.	No		☐ Yes 2 🙀 No	Specify:			y Whit	
in 72 ho e. nan "na	Completed	15. Deceder (Specify only higher Elementary/Seconday (0-12)	nt's Education est grade completed) College (1-4 or 5	i+)	(Give k	ent's Usual Occupa sind of work done do O NOT use retired)		orking	16b. Kind of E	Business Ind	lustry
d with tygien ther ti nt, the	Be C	1.2 17. Father's Name (First, Middle, I			Homen	naker			Own Ho		
l be file lental ⊁ rked o tic eve	10	Nicolas Dietur	,				18. Mother's Na Louisa	ame (First, Middle, Raymond		7e)	
permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Exence.		19a. Informant's Name/Relationsl				g Address (Street a Serenity	nd Number or R		r, City or Town,		
age 1 an ent of He at: If item y or othe	200	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from State	CE	emetery, crem	sition (Name of patory or other place		Date 18/2011	20c. Location	•	wn, State Maryland
permit, F Departm Importal any Injul		21. Signature of Funeral Service L		/ DI u	22.	. Name and Address	s of Facility Ru	ick Tows	n Funer	al Ho	me, Inc.
	- 2	23a. Part 1. Enter the disease, or	complications that caused	the death		.050 York r the mode of dying		Towson, N	<u>-</u>	1 2120	Approximate
Physician/ Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a <u>0 e</u>	cti	C	skno	sis				Interval Between Onset and Death
Examiner		,	Due to (or as a	a conseque	ence of):						-
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequi	anca cij:	_					
s be executed sician and e burial-transit	cal Exa	that initiated events resulting in death) Last	c. Due to (or as a	a conseque	ence of):						-
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal	death 3	Ectopic pregnancy Other (specify)	′		- 1	ate of delive onth	ry Day Year
res that I signed b	d by P	Part II. Other significant condition	ens contributing to death be			nderlying cause give	en in Part I.				e cause of death?
tw requi	plete		7	1,,,,				24a. Was a	an 24b.	Were autop	sy findings available
n: The la ficate ha r, page		25. Was case referred to medical						1 🗆 Yes	rmed?	death?	npletion of cause of
/sicial s certi directo	To Be	examiner?	Hospital:	nt 2 🗆 🗆	R/Outpatient	Othor	ce of Death (Che				
ling Phy n. After thii 'uneral o		27. Manner of Death 1. ✓ Natural 5 ☐ Pendin	28a. Date of injur	у [2	28b. Time of injury	28c. Injury work?	at	Home 5 Resid			
r Attend er death rector: / by the f	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be		ne, farm, stre		′es 2 □ No	28f. Location (S		per or Rural I	Route Number,
spital or		29a. Certifier 1 Certifying	Physician: To the best of r		dge death o	coured at the time	date and place	City or Tow		ner as etated	1
the Ho thin 24 h the Ful	Medical	(Check 2 \square Medical E	Nurse Practioner: To the basis of ex	amination	and/or investi-	gation, in my opinion eath occurred at the	i, death occurred time, date and p	at the time, date a	nd place, and du	ie to the caus	se(s) and manner stated.
5 ≥ 6 0		29b. Signature and title of certifier	nonio			29c. License	s G Y (29d. Date signe アントィ	d (Month, D	ay, Year)
10		30. Name and address of person v	who completed cause of de			int))1:	L- MD21234
Stat	-	31. Date filed (Month, Day, Year)	32. Registra	r's Si n atu	re for Ka	1	Thes	1700 60	ioso Pa	ند لاس ((ا	- MUSIS3A
Registra	ır	.1111 1 4 20	17 Canera	P. 1	4 44						

			1 - For State of Maryland / Dep Registrar Ce	eartment of Health and Martificate of Death		ene	22667
	Physicia		1. Decedent's Name (First, Middle, Last) Winifred L. O'Donnell		2. Date of Death	Day Year	3. Time of Death
	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 12,	4c. County of Death	12:50 PM
مدر		М	11601 Bunnell Court South 5. Social Security Number 6. Sex 7. App (In vrs. last hirthday)	Potomac		Montgom	
	Funeral Director		349-30-7431 1 □ M 2 🖫 F 79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You	g. Births 1931 New	place (State or Foreign York
	ind ihow at	្គ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot	ocation			0d. Inside City Limits
	Maryla 28a-f s otified	Director	Maryland Montgomery Potomac				1 ☐ Yes 2 🛣 No
	vith the 23a or st be n	ra D	10e. Street and Number 11601 Bunnell Court South	10f. Zip Code 20854		g. Citizen of What Coun	•
	death v items ier mu	Funeral	11. Marital Status 12. Was December Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec	cifv Yes or No-	United Stat	
39	after call, or zamin	þ	1 Never Married 2 X Married 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto F 1 Yes 2 X No Specify:	Rican, etc.)	Black, White, e	
2-0	"natur	plete	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation	16	6b. Kind of Business Inc	
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nd 2	be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai		ille .
Z	should be file and Mental I is marked o raumatic eve	잍	Stephen Donald Locke		ne Coffey		
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. If Heath and Mental Hygiene, items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) James F. O'Donnell/Husband 116	ng Address (Street and Number or Rural D1 Bunnell Court So	Route Number, Ci	ty or Town, State, Zip C Comac, Mary	1and 20854
ore,	ge 1 an t of He If item or othe		20a. Method of Disposition 20b. Place of Dispo			lc. Location - City or To	
E E	permit. Page 1 a Department of H Important: If ite any injury or oth		4 Donation 5 Other (Specify) All Souls	Cemetery 20	11 G	ermantown,	
ñ	permit. Departr Imports any inji	3	wilking a Romenley MO1173 30	Name and Address of Facility Bert A. Pumphrey Fune: O W. Montgonery Avenue	ral Home, I e, Rockvil	Rockville, In le, Maryland	c. 20850
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Ph_sici_n Medical	ì	Immediate Cause (Final disease or condition resulting in death) a. Cardiomyopathy Due to (or as a consequence of):			\(\frac{1}{2}\)	Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions, b. Breast Cancer				
	ted nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury				
	execurian and rial-tra		that initiated events c. Due to (or as a consequence of):	-			
	physici	edical	d				
120	ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live Birth 2 □ Fetal death 3 □	75		23d. Date of delive	rv
DOX	To the hospital or Autending Priysician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me		Other (specify)			Day Year
7.	rnat tr gned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
ecords,	equires				1 🗌 Yes	2 🛚 No 3 🗆 Prob	ably 4 🗀 Unknown
ည	e has bage 2 s	Completed			24a. Was an autopsy performed	prior to con	sy findings available npletion of cause of
VII I	ertificat		25. Was case referred to medical examiner?	26. Place of Death (Check of	1 □ Yes 2 🛚		2 □ No
	rnysic this or ral dire	욘	1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of injury 28b. Time of			e 6 Other (Specify)	
	ath. Ir. Affer	icate	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	3d. Describe how is	njury occurred	
IVISIOII	after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	Bf. Location (Stree: City or Town, Si	t and Number or Rural I tate)	Route Number,
ם ב	hours hours uneral	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death of	occured at the time, date and place, and	due to the cause(s	s) and manner as stated	
440	ithin 24 the Formplete		(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, c	igation, in my opinion, death occurred at the time, date and place,	ne time, date and pl and due to the cau	lace, and due to the caus use(s) and manner as stat	se(s) and manner stated. ted.
þ			· Sem	29c. License number 413328	\mathcal{G}	Date signed (Month, D	ay, Year)
	12 m		30. Name and address of person who completed care of death (item 23a) Type, P		/	7	0.7
	State	e	31. Date filed (Month, Day, Year) \$2. Registrar's Signature	oir Road, N.W., Was	shington,	D.C. 2000	U /
	Registra	r	JUL 1 4 2011 Seven J. Jak				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	_		For State Registrar	State of Ma	aryland		rtment of I tificate of I			gien Reg. N	71111	22448
	Physicia		1. Decedent's Name (First, Middle, L ${f Elain}$,	owel	1			2. Date of De Month		Day Year	3. Time of Death
The same of the sa	Medic Examin		4a. Facility Name (if not institution, g	ive street and number)	JWET	Т.	4b. City, Town, o	r Location of Dea		//	1c. County of Dea	`
			ST. AGNES H	1	(In use les	st birthday)	BALT If Under 1 Year	IMORE If Under 24 Hr	0 0 Date (B)		NA	
	Funeral Director		218-28-1305 Usual Residence of Decedent		7 8	Yrs.	Months Days	Hours Mir		v, Year,	3	thplace (State or Foreign nuntry) MD
	laryland 3a-f shov tified at	ector	10a, State 10b. County ND NA	A		Town or Loc						10d. Inside City Limits X X X Yes 2 □ No
	with the N 23a or 2 ust be no	eral Dir	10e. Street and Number 6812 Upper M:	ills Circl	Le		10f. Zip Code 2122	 28		10g. (Citizen of What Co	puntry?
9800	permit rage i and 2 should be the within 72 hours sher beath with the maryland beath with the maryland beatherner of Health and Mehral Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N N If Yes, Give Year or Dates.			das Decedent of H Yes, specify Cuba ☐ Yes 2 🗓 No		Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit	^{e, etc.} African
Baltimore, Maryland 21215-0036	ene. r than "nat he Medica	Comple	15. Decedent's (Specify only highest Elementary/Seconday (0-12) 12th Grade	Education grade completed) College (1-4 or 5+ NA	-)	(Give k	ent's Usual Occup ind of work done of NOT use retired)	during most of wo	orking		Kind of Business ome mal	
land 2	lental Hygi rked other tic event, 1	To Be	17. Father's Name (First, Middle, Las Clinton			Done	3616	18. Mother's Na	ame (First, Middle, e			(C1
, Mary	o z stoulo salth and N n 27 is ma er traumat		19a. Informant's Name/Relationship Calvin Wheel			19b. Mailing 6812	Address (Street of Upper	and Number or R Mills	ural Route Numbe	r, City o Ba	or Town, State, Zi ltimore	o Code) e, MD 21228
imore	rage tal ment of He tant: If iten ury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Pla	nce of Dispos metery, crem TTLSO	ition (Name of atory or other place n Fores	st 07-	Date 20-11	Ow	_	111s, MD
Balt	Depart Import any inj		21. Signature of Funeral Service Lice	diminos	ta	<u> </u>		Gilmor	Street	Ва		ome P.A. e,MD 21217
(9)	nysician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	15		the mode of dyin	g, such as cardia	c or respiratory an	rest,		Approximate Interval Between Onset and Death \$\int_{A} \cdot S\$
E	xaminer	Jer	Sequentially list conditions, if any leading to immediate	b. Due to (or as a d								
760 cate be executed	g physician and strensit	ledical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a								
760	hysiciar he buri	dical		d								
30x 68	e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	☐ Fetal of	death 3	Ectopic pregnand Other (specify)	гу			23d. Date of de Month	livery Day Year
ധര് s, P.O.	been signed by the should be detached		Part II. Other significant conditions	contributing to death but	not resul	ting in the un	derlying cause giv	en in Part I.				the cause of death?
ELAINS Records, F	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed by							24a. Was autop perfo 1 Yes	osy rmed?	prior to death?	topsy findings available completion of cause of
tal F	ertifica ctor, p		25. Was case referred to medical examiner?	[(I				ace of Death (Che		2 🗀 r	No I TE	S ZEINO
γ Z	this c	۵	1 Yes 2 No	Hospital: 1 Inpatien 28a. Date of injury		R/Outpatient 8b. Time of	3 DOA Othe	4	Home 5 Resid			ify)
Poweru Division of Vital tal or Attending Physician	death. tor: After the fune	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	(Month, Day,)	Year)	injury	M 1 □	? Yes 2 □ No				
Divis	urs after or ral Director of the contract of t		4 ☐ Homicide determine	building, etc. ((Specify)				City or Tow	n, Stat	e)	ral Route Number,
the Hosp	hin 24 ho the Fune mpleted f	Medical	(Check 2 Medical Example only one) 3 Certifying Nu	ysician: To the best of m niner: On the basis of exa irse Practioner: To the be	mination a	and/or investig	ation, in my opinic ath occurred at the	on, death occurred time, date and pl	at the time, date a	nd plac	e and due to the	cause(s) and manner stated
٩	10 %		29b. Signature and title of dertifier	(0)			29c, License	2406		29d. D	ate signed (Month	n, Day, Year) 13 2011
かく	01-		30. Name and address of person who	DEJA (th (Item 2	D Ca	tan f	tve F	Balton	OVE	Mb	21229
	State Registra		JUL 14:	2011	Jognatur	1 60	Kel					<u> </u>

The law requires that the death certificate be executed physician and s the burial-tran Box 68760 as attending for use as detached 0 Records, certificate or Vital Division

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2011 July 6, 1:40 A^{M} Marquan Powell Antonio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Hospital Fort Washington Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) *Juliany, Birth 1979 **Funeral** Days 1 X M 2 □ F Director 217-17-7039 31 Washington, DC Usual Residence of Decedent a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Directo MD Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a iner must b 1303 Old Cannon Road 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or iten Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Black Specify: þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Angelo Powell Gladys McPherson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important; If item 27 is any Injury or other trauonce. 1303 Old Cannon Road, Ft. Washington, MD Gladys McPherson - Mother 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-9-2011 Staton Memorial 4 ☐ Donation 5 ☐ Other (Specify) Scotland Neck, NC Lionel Whidbee Funeral Home 515 E. 12th St., Scotland Neck, NC 27874 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESD'/OM ACUTE 27/ disease or condition resulting in death) Due to (or as a consequend RESISTANT STAPH ALLYCUS Bacterenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner un known Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>2</u> perdent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide The critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0026262 July 6, 2011 30. Name and address of person eted cause of death (Item 23a) (Type, Print) M.D. 11711 Livingston Rd., Fort Washington, MD 20744 Samuel J. Kleiman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Fer FJ H917 / 26/2011 JH State of Maryland / Department of Health and Mental Hygiene For State 22450 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBINSON Month Year LOIS 1658 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL **GLEN BURNIE** . Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth _{/e.}1953 2011 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Country) MD 1 M 2XX F Min MARCH 13, Months Days Hours 218.62.0080 Yrs Director 58 Usual Residence of Decedent 28a-f show with the Maryland at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 1 Yes 2xx No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code ms 23a or must be n Funeral 311 N ST. SE 21061 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Completed 3 Widowed 4 XXDivorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PHLEBOTOMIST **HEALTHCARE** Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental | ೭ HERBERT CARL ROBINSON ETHEL JANE HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is eny injury or other trains **EILEEN ROBINSON** SISTER 311 N ST. SE GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 🗆 Burial 💥 Cremation 3 🗀 Removal from State cemetery, crematory or other place) BAYVIEW CREMATORY INC 4 Donation 5 Other (Specify) JULY 13, 2011 BALTIMORE, MD 21. Signatur of Funcial Service Lic Ase nce. FINK FUNERAL HOME, P.A. CRECORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph sician CARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last HYPERTENSION nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical HIBH CHOLESTEROL P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, CANCEL 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed COPO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed certificate 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 140 မြ 1 Tes 1 Inpatient 2 R/Outpatient 3 IDOA this After this funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending work within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🛎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature Ltitle of certifie 29c. License number 29d. Date signed (Month, Day, Year, D0067349 July 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW MCGLONE, MD #670 AMMAPOLIS MD ZI40) 2002 MEDICAL PARKWAY SUITE

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Physician /Medical **Examiner** sician and burial-trans \mathcal{R} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} \mathcal{L} Division or Vital Records, P.O. Box 68760, attending physician for use as the buria

Physician

*/Medical

Examiner

Funeral

Director

or 28a-f show a notified at

'natural", or Items 23a or dical Examiner must be r

be filed within 72 hours after de ntal Hygiene. d other than "natural", or Item event, the Medical Examiner r

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiny or other traumatic event one.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

Exami Physician/Medical by Completed Be 2 Certification:

the signed by

has

this

within 24 hours
To the Funeral Dir

death. Il Director: /

page ertificate

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown
9 Unknown

1 Yes 2 No

29a. Certifier

25. Was case referred to medical examiner?

26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

COLUMBIA

and manner stated 29b. Signature and title of certification

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

10062634

HICKERY RIDGE RO

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AWAN 10796 31. Date filed (Mont

State Registrar

DHMH 17 Rev 1/2001

Medical

		_	For State Registrar		State of Ma	aryland	-	artment of I tificate of I		and Mental		ne N 20 I		22452
	Physicia Medic		1. Decedent's Nam Warren		ast) Ltenour Sr.	•				2. Date Mon			Year	3. Time of Death 2237 P M
0	Examin		1	not institution, giv	restreet and number) Hospita	7L		4b. City, Town, o	r Location of	f Death		4c. County of	of Death	
	Funeral Director		5. Social Security N 215-40-62	umber 6. 283			st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		of Birth th, Day Ye	1943	9. Birthp Coun	place (State or Foreign http:// Maryland
	show dat	ţo	Usual Residence of 10a. State	10b. County		10c. City,	Town or Loc	eation						10d. Inside City Limits
	Mary 28a-f notifie	Director	MD	Baltin	nore	Ha1	ethor							1 ☐ Yes 2XXNo
	with the	Funeral D	10e. Street and Nur 4101 Ho	nber 11ins Fe	erry			10f. Zip Code 21227			10g	. Citizen of W USA	hat Cour	itry?
9800	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: If tiem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۾	11. Marital Status 1 Never Marr 3 Widowed	ied 2 🔀 Married 4 🗌 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 IN If Yes, Give Year or Dates.	er in U.S.	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No	an, Mexican,	in? (Specify Yes o Puerto Rican, etc	or No-		, White,	
Maryland 21215-0036	n 72 hou e. ian "nat Medica	Completed	(Spe	15. Decedent's ecify only highest g			(Give k	ent's Usual Occup ind of work done of NOT use retired)	during most	of working	16	b. Kind of Bus	siness Ind	dustry
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lanc	d be file fental H irked of tic ever	일	17. Father's Name (First, Middle, Last)). Ritenc						r's Name <i>(First, M</i> Elizabet				
Mary	should and N is ma auma		19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Number	r or Rural Route N	umber, Cit	y or Town, Sta	ate, Zip C	Code)
e,	and 2 Health tem 27 other to		Karen Ri	tenour-W	life	20b PI:		Hollins sition (Name of	Ferry	Road F		norpe N		land 21227
Baltimore,	t, Page 1 rtment of rtant: If i		1 Burial 2 4 Donation	X Cremation 3 [5 ☐ Other (Soec	Removal from State	l ce	metery, crem .antic	cremator Cremator	су	7-13-201	1 G1	len Bur	nie	, MD
Bal	permi Depar Impo any ir once.	9	2. Six aturadi fu	eral Service	DOG.	DN		Name and Addre						Inc. land 21227
			23a. Part 1. Enter t shock, or hea Immediate Cause (rt failure. List only	nplications that caused to one cause on each line.		1 1			ardiac or respirat	ory arrest,			Approximate Interval Between Onset, and Death
	nysician/ Medical Examiner		disease or condition resulting in death)	in 🕜	a. Due to for as	O CUI		intarc	LON.				+	unknown
		Jer	Sequentially list co if any, leading to in	nmediate 📗	b. Due to (or as a	conseque	ence of):			4			+	
	and transit	Examiner	Cause (Disease or that initiated event resulting in death)	iinjury	c. Due to (or as a				_				1	
092	icate be executed physician and s the burial-transit	edical	resulting in death)	Last	d.	Conseque								
N 687	ding p		IF FEMALE: 23b. Was decedent	-records	23c. If yes, outcome of	f pregnan	CV					1		
Box 68	the atterched for n	Physician/M	in the past 12 in the past 12 in Yes 2 5	months?	1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal	death 3 🗌	Ectopic pregnand Other (specify)	СУ		_	23d. Date Mon		Day Year
WAR Is, P.O.	n signed by	ed by PI	Part II. Other signif	icant conditions	contributing to death but	t not resu	ting in the ur	nderlying cause giv	ven in Part I.	23e.				ne cause of death?
RifeNouR, k Division of Vital Records,	on the hospital of Attending Physician, the law requires that the deam certific within 24 hour after death. To the Funeral Director: After this certificate has been signed by the attending completed filler in by the funeral director, page 2 should be detached for use as	Completed by								24a.	Was an autopsy performed Yes 2	pr de	ior to con eath?	psy findings available mpletion of cause of 2 No
N O I	ertifica ector, p	Be C	25. Was case referre examiner?	ed to medical						(Check only one		I NO	Li res	2 🗀 140
T X	this or	: To Be	1 ☐ Yes 2 ☐ 27. Manner of Death		Hospital: 1 Inpatier 28a. Date of injury		R/Outpatient		4 🗀 Nur	rsing Home 5)
4000	ending eath. or: After hε funer	Certificate:	1 Natural 2 Accident	5 Pending Investigation	(Month, Day,	Year)	injury	28c. Injun work M 1 🗆		I	ribe how ir	njury occurred	i	
√x sivid	itel of And in after d rai Direct ilec in by t	al Certi	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	building, etc.	(Specify)				City	or Town, St	tate)		Route Number,
	ine nosp in 24 hot the Funer	Medical	(Check 2		ysicían: To the best of m niner: On the basis of exa rse Practioner: To the be	ımination a	and/or investi	gation, in my opinio	n, death occ	curred at the time	date and ni	ace, and due t	o the car	ise(s) and manner stated
	Mith		29b. Signature and	1/2	Lmo				1353		1	Date signed		
1_			30. Name and addr	as of person who	completed cause of dea	ath (Item 2	(3a) (Type, Pr	int) WE Bi	ltimo	re, Ma	ryla	nd :	212	.29
	State Registra	e (JUL 1 4	h, Day, Year)	32. Registrar's	s Signatu	re							
DHM	H 17 Rev 7/200		-							=				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 22453 Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2121 EHR BELLE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Heritage Harbor 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (*Month, Day, Year*) May 8, 1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 F Months North Carolina Yrs **Director** 217-16-0791 Usual Residence of Decedent 28a-f shov 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21032-1251 USA 1038 Shore View Cir death 12. Was Decedent Ever in U.S. Armed Forces? 1 $\stackrel{\wedge}{\rm M}$ Yes 2 $\stackrel{\vee}{\rm L}$ No 1942-If Yes, Give Year or Dates. 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white 'natural", 3 ☒ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 0 timekeeper airport Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ James Olin Higgins Edith Ann Rowland permit. Page 1 and 2 should be Department of Health and Meni Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Rollins - daughter 1038 Shore View Cir; Crownsville, Maryland 21032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of neral Service Licensee 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph si i n disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be 1 Yes Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending within 24 hours after death.

To the Funeral Director: A 2 \square No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the be st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person

31. Date filed (Month

Day, Year)

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 Carrie Virginia Ruff 2011 9:45p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Keswick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7 Age (In vrs. last hirthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Hours 219-22-0260 85 0477771926 Maryland Director Usual Residence of Decedent or 28a-f show 10a State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21215 U.S.A. 3632 Fords LN Apt 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 0. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Wildowed 4 Divorced Specify: Black Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Social Security Adm Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruth Lewis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic s Luther Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3632 Fords LN, Apt C., Baltimore, MD 21215 Betty Riddick(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, King Mem. Park 07/18/11 Baltimore, MD 21. Signature of Funeral Service Licensee Josephodro Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a a consequence Exami Hospital or Attending Physician: The law requires that the death certificate be executed Advanced and trans that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mg nths? Pregnant at time of death Month Day Year No the 9 Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate 25. Was case referred to medical Be 26. Place of D h (Check only one) examiner? Hospital 2 🗹 No Other: 1 Tyes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director: Af 1 Yes Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) 112

Registrar
DHMH 17 Rev 7/2009

State

JUITE 30

821 N. EUTAW ST

BACTIMORE MP ZIZO

oh who completed cause of death (Item 23a) (Type, Print)

SHARMA

VIJAT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4c, perPHYS#10b, perFH, G918, 8/25/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Margaret | Rockenbaugh Jul 12. 2011 8:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of DeathBaltimore
Howard 4b. City, Town, or Location of Death **Ellicott City** 2417 Westchester Ave 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov 25, 1915 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 🗆 M 2 🔀 F Hours 213-10-7990 95 Director Yrs MD Usual Residence of Decedent 28a-f show 10b. County Baltimore 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at irector 10c. City, Town or Location 10d. Inside City Limits MD Howard **Ellicott City** 1 Yes 2 No ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2417 Westchester Ave 21043 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Maryland 21215-0036 hours after 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Baltimore Co., Public 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked of any inJury or other traumatic eve ဂ္ John Zellmer Katie Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Rockenbaugh Nephew 2417 Westchester Ave Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗖 Removal from State Jul 15, 2011 Ellicott City, Maryland **Good Shepherd Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service License 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Epter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy ģ 5 Other (specify) Month Year Pregnant at time of death Dav the detached 9 I Inknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be No 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Hospital Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify 4 Universing Home Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Natural 5 Pending Accident Investigation Director: 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of cert

30. Name and address of p

31. Date filed (Month, Day,

MPV

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tem 23a) (Type, Print)

pleted

ise of death

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ 22456 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hazel Virginia Russell Month Jul 9, 2011 Year 2:35 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Futer Care Old Court** Randallstown **Baltimore** 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Sep 19, 1927 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days Min 29-22-3158 83 Marylan Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD **Baltimore** Woodlawn 1 🗆 Yes 2 🗹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5509 Gwynndale Ave. 21207 U.S.A. permit, Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Line Supervisor Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Louis McDonald Elizabeth Funk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Gwynndale Ave. Gwynn Oak, MD 21207 19a. Informant's Name/Relationship (Type, Print) Vernon E. Russell Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Good Shepherd Cemetery Jul 13, 2011 Ellicott City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name Stack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): If they, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death be detached signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 1 Tes ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural wark 1 🗌 Yes 2 No Investigation Could not be the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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ne k	Physicia Media	cal	Lydia Stevenson							Month L	DAY -2	(ear /	3. Time of Death
	Examir	ner	4a. Facility Name (if not institution				4b. City, Town, or		of Death		4c. County o		
	Funeral	_	Morning H 5. Social Security Number	ouse of Saty	yr Hlll Age (In yrs. last)	hirthday)	Baltimor	e If Under:	24 Hrs 0	. Date of Birth	Balti		
	Director		220-40-8579 Usual Residence of Decedent	1 □ M 2 🔀 F	96	Yrs.	Months Days	Hours	Min.	(Month, Day,	^{Year)} 1914	Count	lace (State or Foreign ry) yland
	and Show	5	10a. State 10b. Count	у	10c. City, To	own or Loc	ation					1	0d. Inside City Limits
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	MD. Balti	more	Bal	timor	e						1 🗌 Yes 2 💢 No
	the land	Ë	10e. Street and Number				10f. Zip Code				10g. Citizen of Wh	at Coun	try?
	s 23; nust	ners	8800 Old Har	ford Rd.			21234					USA	
	death item ner n	큔	11. Marital Status	12. Was Deceden Armed Forces		13. V	as Decedent of His Yes, specify Cuban	panic Orig	gin? (Specif	y Yes or No-	14. Race		
36	after Il", or xami	d by	1 ☐ Never Married 2 ☐ Ma 3 🕱 Widowed 4 ☐ Divorce	rried 1 Tes 2 1 If Yes, Give	K No		Yes 2 No			, 41-1,	Specify:	White, e	
21215-0036	atura cal E	Completed		ent's Education		6a Deced	ent's Usual Occupa	tion					
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	withii giene er th		Liementary/deconday (0-12)	+1		Homem	aker				Own Hom	e	
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Ma	2 sho Ith and 27 is i	12	19a. Informant's Name/Relation Susan S. Cowle		11/1		g Address (Street ar					te, Zip C	ode)
	F Heal		20a. Method of Disposition	s/ Daugitter	20b. Place	e of Dispos	riminic C		Dat		21013 20c. Location - C	ity or To	wn State
MO	Page 1 nent of ant: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		110		atory or other place alley Men		7-15-		Timoniu	•	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		21. Signature of uneral Service		Dula	-4-	Name and Address	of Eacility	son F	uneral	Home, I	nc.	
	HD = 60		23a. Part 1. Enter the disease, of		and the a decetty D		1050	YO.	rk Ka	. lows	on, MD.	<u>21</u> 20	
в	er company		shock, or heart failure. List	only one cause on each li	ine.	o not ente					st,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence	al	The	on		19		-	
-	Examiner			Buc to (or a	is a consequenc	Je 01).							
	_	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequenc	ce of):							
	cuted	xam	Cause (Disease or iinjury that initiated events	c								\perp	
	death certificate be executed re attending physician and ed for use as the burial-transit	alE	resulting in death) Last	Due to (or a	s a consequenc	ce of):							
760	cate b physi the b	edical		d								+	
687	ath certifica attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							23d. Date	of delive	n/
Вох	leath e atte d for I	sicia	in the nact 12 months?	4 Pregnant	t at time of deat	eath 3∐ h 5□	Ectopic pregnancy Other (specify)				Monti		Day Year
O. E	hat the de ed by the detached	Physician/M	1 Yes 2 No 9 Unknow	9 ∐ Unknowr									
9.	w requires that s been signed t should be det	by	Part II. Other significant condit	ions contributing to death	n but not resultir	ng in the ur	derlying cause give	en in Part f			acco use contrib		
rds	equire een s oould	eted								1 □ Ye			ably 4 Unknown
of Vital Records,	The law requires that the ate has been signed by the page 2 should be detach	Completed								24a. Was ar autops perforn	y pri	re autop or to com ath?	sy findings available opletion of cause of
Ä			25. Was case referred to medica				00 50	- (0 - 1		1 🗆 Yes 2		Yes 2	2 No
/ita	Physician: this certific	To Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	atient 2 - ER/	Outpatient	Other		h (Check on		nce 6 Pother	ecus	Jeb
of	ig Physicar this neral di		27. Manner of Death	28a. Date of in	ijury 28k	outpatient o. Time of injury	28c, Injury a	at			w injury occurred	Specify)	Lion
on	Attending or death. ector: After by the fune	fica		igation	yay, rear)	ii ijui y	work? M 1 □ Y	es 2 🗌	No				
.≥	al or Attending Physis after death. Il Director: After this din by the funeral d	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined 28e. Place of Ir	njury - At home, etc. (Spec <i>ify)</i>	farm, stree	et, factory, office		28f	Location (Str City or Town,	reet and Number (, State)	or Rural I	Route Number,
<u>-</u>	Hospital 24 hours a Funeral I	Medical	29a. Certifier 1 Certifyin (Check 2 Medical	g Physician: To the best of Examiner: On the basis of	of my knowledg	e, death o	ccured at the time, o	date and p	place, and d	ue to the caus	se(s) and manner	as stated	I.
	To the Hospital or At within 24 hours after or To the Funeral Direct completed filled in by	Me	only one) 3 Certifyin 29b. Signature and title of certifie	g Nurse Practioner: To the	ne best of my kno	owledge, de	eath occurred at the	time, date	and place, a	nd due to the	cause(s) and manr 9d. Date signed (/	er as sta	ted.
			ball	100h -	~ M	2	D15	8	22	-	Jack 1	1,5	011
	10		30. Name and address of persor	who completed cause of	death (Item 23a	a) (Type, Pr	int)	1	1	1	A. C	, つ	106/
	Stat		31. Date filed (Month, Day, Year)	15 698 Regis	trar's Signature	24	13	100	a	184	ourne		2001
	Registra	- 4		011 Series	1 1.	par	/						

1-05180	Please Type or Print in Black I		The state of the s	
hillip Showalter	1- For State C6	eartment of Health and Mental I ertificate of Death	Reg. No.	
Physician Medical Examine		llin A. Showalter	2. Date of Death Month Day Year July 11, 2011	3. Time of Death 1920 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		ath
	Johns Hopkins Bayview Medical Center	Baltimore	n/a	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 202–48–3155 1 Am 2 F 49	last birthday) If Under 1 Year If Under 24H Months Days Hours Mi		Birthplace (State or eign Country)
A .	Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Location		
ow any	10a. State 10b. County 10c. City PA York			10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show i at once.	10e. Street and Number	Wellsville	10g. Citizen of What C	Λ
ith the Maryland 23a or 28a-f sho notified at once	45 Lisburn Rd.	17365	USA	··· , ·
with t	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- 14. Race - Am	erican Indian, Black,
or death v	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.) White, etc	
s after ral", o	3 Widowed 4 Divorced of Divorced or Dates:	1 Yes 2 No specify:		hite
5-0036 led within 72 hours after the within 72 hours after the "natural", the Medical Examiner Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		s/Industry
hin 72 hin 72 e. e. edical	9 n/a	Mechanic	Auto Boom	alima
21215-0036 ould be filed within 72 hour I Mental Hygiene. In marked other than "matu ic event, the Medical Exam To Be Completed	17. Father's Name (First, Middle, Last)		Auto Recy (First, Middle, Maiden Surname)	ering
2121; hould be fil hould be fil is marked is marked ritic event, i	Glenn Showalter	Dorothy		
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fabe traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or		ite, Zip Code)
and 2 sho ealth and 2 cen 27 is traumati	Gail L. Showalter/wife 20a. Method of Disposition 20b.	45 Lisburn Rd., Well Place of Disposition (Name of cemetery.	Date 20c. Location - City	or Town. State
OFE ges 1 it of H i: If ii		crematory or other place)		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: Witen 27 is in injury or other traumatic	Donation 5 Other Speaily: C1 21. goutur of uneral Service in e	remation Direct Service		
Dep Dep I	Beyan Molary	Lemmon Funeral Hor 10 W. Padonia Rd.	me of Dulaney Vall	ley, Inc.
Physician	23a. Part I. Into the disease, or complications that caused the death failur. List only one cause on each line.	n. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Carse (Final disease a Complications	of smoke inhalation and	l thermal injuries	Dante
	or condition resulting in death) Due to (or as a consequence of	of):		
PE	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):		
aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	ď).		
executed in and in transit cal Exa	f events resulting in death) Last Due to (or as a consequence of d.			
ਹ ਜ਼ਰ। ⊆	☑ UNPENDED ☐ AMENDED23a,27,2	8a-f,per me,g919 9-26-1	1 sm	
760 icate b i physi ithe bu	IF FEMALE: 23c. If yes, outcome of preg 23b. Was decedent pregnant in the		23d. Date of delive	-
ox 68760, anth certificate be ex- attending physician for use as the burial - sician/Medic	past 12 months?	2 Fetal death 3 Ectopic pregnates 5 Other (Specify)	ancy Month	Day Year
Dox 68760, the death certificate below the attending physicic ched for use as the burich Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown	o other (openity)		
	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute t	_
S, P.(uires that an signed ld be deta			1 Yes 2 ✓ No 3 Pr	
Cord law rec law rec 2 shou			autopsy prior to	autopsy findings available completion of cause of
tal Records, clan: The law requires certificate has been sig ector, page 2 should be Be Completed			1 ✓ Yes 2 No 1 ✓ Y	
Division of Vital Records, tal or Attending Physician: The law requints after death. al Director: After this certificate has been a Director, page 2 should bettin by the funeral director, page 2 should briffication: To Be Completed	25. Was case referred to medical examiner? Hospital: 1 ✓ Inpatient 2	26 Place of Death (Check FR/Outpatient 3 DOA Other Nursin		
of V r Phys r Phys eral di	1 Yes 2 No I I I I I I I I I I I I I I I I I I	ER/Outpatient 3 DOA Outlef4 Nursir 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Oth	er:
ion c tending eath. tor: Af the fun	1 Natural 5 Pending (Month, Day, Year)	fd 3:00 am 1 Yes 2 X No	subject in garage	fire
S 4 5 8 8 5	21 /100/00/11	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State) 45 Lisbut	tural Route Number, City
Division o ospital or Attending hours after death. nuneral Director: After y filled in by the function:	4 Homicide determined (Specify) Re	sidence	Wellsville, PA.	III KU.
Divis To the Hospital or Avertin 24 hours after or To the Funeral Direct completely filled in by Medical Certific	29a. Certifier 1 Certifying Physician: To the best of my knowledgenes) 2 Medical Examiner: On the basis of examination and manner stated.			
E S H S E	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)
	Alle Grassell, MD	O.C.M.E.	July 12, 2011	
and	Name an address of person who completed cause of death (Item Melissa Brassell, MD	The second secon	re. MD 21223	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatu			
Registrar	JUL 1 4 2011 Bene &	parket		
DHMH 17 Rev 1/2001	CEME	ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22459 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Donald R. Strolle July 11, 2011 6:15 pM **Medical** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 № M 2 🗆 F Months June 29 220-20-0062 Director 84 1927 Yrs. Mary Tand Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d Inside City Limits MD Harford Forest Hill 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3353 Kreitler Road 21050 U.S.A. hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 51-56 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Quality Control Inspector Electrical 12 and Mental Hygie is marked other permit. Page 1 and 2 should be filled.
Department of Health and Mental Hy, important: If item 27 is marked any injury or other the space. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Strolle Raymond Martha Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice K. Wisler-daughter 3353 Kreitler Rd., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 7/15/11 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Shymician/ Onset and Death disease or condition concr Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or imjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death Month 2 No the g Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mperansin After this certificate has been si funeral director, page 2 should 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 ANO Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Dea Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

only one 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wes

32. Registrar's Si

6701

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N. Charles

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22460 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 20<u>11</u> Physician/ 6:34 P M Charles Henry Stout July . Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Parkville 5 Beaver Pond Circle If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1 X M 2 🗆 F Hours (Month, Day, Ye 8/21/193 79 Director 213-28-8128 Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at with the Maryland Director 1 Yes 2 XNo Parkville Baltimore Maryland 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? items 23a 21234 5 Beaver Pond Circle U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner: Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steamfitter Master Plumber Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rose Stanpone Charles Thomas Stout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 837 Staffordshire Road Cockeysville, MD 21030 Katherine Bivons / Dtr. Stout 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 7/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. Towson, Maryland Charles 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Çhysician/ melanome disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Exam attending physician and for use as the burial-transit Due to (or as a consequence of): certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy ned by the atter in the past 12 months? Month 5 Other (specify) Dav Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 2 00 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Funeral L the Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 027730

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARY COHON, MD 6569 N. CHANLES IT. BALTIMONE, NO 21204

State of Maryland / Department of Health and Mental Hygiene []

			1 - State OF N	nai yianu i		tificate of D			Reg. No.	1 22401	
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month July		3. Time of Death	
or me	Medic Examin		Henry L. Stokes 4a. Facility Name (if not institution, give street and number)			4b. City, Town, or	Location of Deat		10 20 4c. County of I		
-	i Lamin		3402 Crosswood Drive		1	arford					
	Funeral		1 1 M A A T E	ge (In yrs. last t		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.			Birthplace (State or Foreign Country)	
	Director		220-20-6701	82	2 Yrs.			Sept.	181928	MD	_
	fand shov	tor	10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits	_
	28a-	Director	Maryland Harford			,	berdeen		-	1 Yes 2 K No	j
	ith the 23a or st be r	ral	10e. Street and Number			10f. Zip Code	21001		10g. Citizen of Wha	•	
	tems ?	Funeral	3402 Crosswood Drive 11. Marital Status 12. Was Decedent	Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar		pecify Yes or No-		SA American Indian,	_
9000	filed within 72 hours after death with the Maryland tral Hygiene. So dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ě	1 ☐ Never Mamied 2 ☑ Married 1 ☐ Never Mamied 2 ☑ Married 1 ☑ Yes 2 ☐ 1 ☑ Yes 2 ☐ 1 ☑ Yes 2 ☐ 1 ☑ Yes 3 ☐ 1 ☑ Yes 4 ☐ 1 ☑ Yes		i i	Yes, specify Cubar Yes 2 No		o Rićan, etc.)	Black, V	White, etc. White	
15-	72 ho n "nat 1edio	Completed	15. Decedent's Education (Specify only highest grade completed)	11	(Give ki	ent's Usual Occupa ind of work done di	ition uring most of wor	king	16b. Kind of Busin	ess Industry	
212	filed within Il Hygiene. I other than vent, the N		Elementary/Seconday (0-12) College (1-4 or 9	5+)	life. DC	NOT use retired) Mecha	anic		BP Oil	Company	
pu	filed tall Hyg	o Be	17. Father's Name (First, Middle, Last)	•			18. Mother's Nar	ne (First, Middle,	Maiden Surname)		_
ya	should be file and Mental 7 is marked c raumatic eve	υ	David Stokes				Margue		Leiman		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship (Type, Print) Janet K. Stokes (spou	se)					r, City or Town, State en , MD 21		
Jore	ge 1 ant of H: If ite		20a. Method of Disposition 1 □KBurial 2 □ Cremation 3 □ Removal from State	e ceme	etery, crem	ition (Name of atory or other place		Date y 13	20c. Location - Cit	y or Town, State	
ij	nit. Pa artme ortani injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service to use	[Mary]		Veterans Name and Address		2011		lle, Maryland	_
B	permit Depar Impor any in		July 2 54		22.			Road, P	s Funeral asadena,	Home, P.A. MD 21122	ļ
	Pnysician/		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir Immediate Cause (Final	d the death. Do	o not enter	the mode of dying	, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	a consequenc						+	H
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as	MENT	IA						
	ted nsit	Examiner	cause. Enter Underlying	a consequenc	-	3					
	execu an and ial-tra	Exa	that initiated events c.	a consequenc	** * * *	-					٦
8760	icate be executed physician and s the buriat-transit	dica	d								
687	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy							
Box 68	eath certifice attending p	Physician/Medical	in the past 12 months? 1 Live Birth	2 Fetal de		Ectopic pregnancy Other (specify)	′		23d. Date of Month	f delivery Day Year	Ì
С	the de by the tachec	hys	9 ☐ Unknown 9 ☐ Unknown								_
Records, P.O.	requires that the de been signed by the s should be detached	۾	Part II. Other significant conditions contributing to death	but not resulting	g in the un	derlying cause give	en in Part I.	23e. Did to	/	e to the cause of death? Probably 4 Unknown	
Sor	has bee le 2 shou	Completed						24a. Was		e autopsy findings available to completion of cause of	\dashv
Re	The la	Com						autor perfo	rmed? deat		
ta	ician: certific rector,	Be	25. Was case referred to medical examiner?			26. Plac	ce of Death (Chec	ck only one)			
<u>5</u>	y Phys er this eral dii	e: 10	1 ☐ Inpat 27. Manney of Death 28a. Date of inju	ient 2 ER/6	Outpatient Time of	3 DOA 28c. Injury	4 U Nursing H		dence 6 Other (S	pecify)	\dashv
ou	anding sath. rr: Afte	licat	1 ☑ Natural 5 ☐ Pending (Month, De 2 ☐ Accident ☐ Investigation	iy, Year)	injury	work?	′es 2 □ No	200, 20001130 1	ingury occurred		
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Notice of the could not be determined)									Rural Route Number,		
	ne Hospit n 24 hour ne Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of Certifying Physician: To the basis of certifying Nurse Practioner: To the	examination and	d/or investic	ation, in my opinion	. death occurred a	at the time date a	nd place, and due to t	the cause(s) and manner states	d.
	Voithi Com		29b. Signature and tale of certifier	43		29c. License			29d. Date signed (M		
	atlan		· /////// ~ //	<u> </u>		194	5421		JULY 11	, 2011	
	0, 9,		30. Name and address of person who completed cause of o	leath (Item 23a) (Type, Pri	nt)				REL HIL	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Teal JULY 8:30 A M 10 ROSE D SCHOFER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTH OAKS HEALTH CENTER BALTIMORE 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min 05/14/1910 Director Yrs MD 214-20-7355 101 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location irector 1 Yes 2 V No MD BALTIMORE BALTIMORE ۵ 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a on traumatic event, the Medical Examiner must be i Funeral 725 MT. WILSON LANE 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. WHITE Completed 3 Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 12 EXECUTIVE SECRETARY U.S. GOVERNMENT should be filed with and Mental Hygien 7 is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DUKE SCHUMAN BESSIE HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3502 ROUND HOLLOW ROAD, BALTIMORE, MD MITZI GLICK/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place, EBREW ORTHODOX, EMORIAL SOCIETY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/12/2011 BALTIMORE, MD 21. Strature of Funeral Service Lin nsee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition ea/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or imjury that initiated events resulting in death) Last death certificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death signed by the a hed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? _≙ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2: autopsy Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work?
1 Yes 2 No death. after death | Director: / Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a 29a. Certifie Feetifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical within 24 hor To the Fune completed fi 29b. Signature and title of certifier 30. Name and address of person who co State

Registrar

Baltimere Zibell MD Smith Year) 1 4

DHMH 17 Rev 7/2009

ause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

037573

MD

29d. Date signed (Month, Day, Year)

21709

11,2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thorton RANCES 1930 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marthond Medical N/A University of BALLMORZ 7. Age (In yrs. last birthday) 49 vrs If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6. Sex Months Month Day Year 12/14/61 214-82-4630 1 🗆 M 2 🔀 F Country Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Baltimore Director MD N/A 1X Yes 2 No 10f. Zip Code 21044 10e. Street and Number 11747 Lone Tree Court 10g. Citizen of What Country? Funeral USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No African Specify Amer. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Nursing 12 of Health and Mental Hygie If item 27 is marked other ir other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Little Rose Mae Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11747 Lone Tree Court, Columbia, MD 21044 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Sheena Thornton/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/18/11 cemetery, crematory or other place Cedar Hill Cem Glen Burnie, MD Buriat 2 Cremation 3 Removal from State 4 Donation 5 2 pher (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA Signature of Fune Service Licens 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Stuss RENAL 7 Months END disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗹 No 1 Yes 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRNP R. Klawitter. R155115 July 13, 2011

DHMH 17 Rev 7/2009

Registrar

State

27

Cens

South Geranz Street Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Klawitter

1 4 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician Alvina lurnage H:10 A M July 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 F 61 214-54-6432 MD **Director** Dec.18,1949 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. and I have 17 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location Examiner must be notified at Director X□ Yes 2 □ No n/a Baltimore MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21206 5605 Sinclair Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Bace - American Indian. 11. Marital Status 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ Specify:Black 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Johns Hopkins Hosp Supply Coordinator llth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eldora Molock James Alston ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4415 Orchard Ridge Blvd. Balto, Md. 21213 19a. Informant's Name/Relationship (Type. Print) DeShawn D. Moody (daughter) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Removal from State July 20,2011 Balto,Md. 4 ☐ Donation 5 ☐ Other (Specify) Tire of Fun Fall Service Lice 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 2 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. On not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** patocellular metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of, The law requires that the death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) 2 14 No by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 **N**o 1 Tyes 2 Nn 1 Tyes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury this 27. Manner of Death 1. Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation injury 1 Yes 2 🗌 No 2 Accident the Funeral Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a the Hospital

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

11.2011

29c. License number

RES-2000

		•	1 - State of N State of N Registrar		artment of Health a rtificate of Death	nd Mental Hygi Re	ene eg. N 201	22465
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Rolarit Wesn	21		2. Date of Death		3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Baltmore		4c. County of D	
	Funeral Director			ge (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 24	8. Date of Birth Min. July 19	9. 1943 M	Birthplace (State or Foreign Country) aryland
	f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland	10c. City, Town or Lo				10d. Inside City Limits
	the Mar a or 28a- be notifi	Funeral Director	10e. Street and Number 2828 Mauldin Avenue	Daltinor	10f. Zip Code	11	1 Yes 2 [
	eath with tems 23 er must	Funera	11. Marital Status 12. Was Decedent Armed Forces		21230 Was Decedent of Hispanic Origin	? (Specify Yes or No-		merican Indian,
9036	ırs after o ural", or I Examin	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ 3 ☒ Widowed 4 ☐ Divorced The property of the pro	Z No	If Yes, specify Cuban, Mexican, F 1 ☐ Yes 2 🎇 No Specify:	euerio nican, etc.)	Specify: W	/hite, etc. hite
215-(should be filed within 72 hours after death with the Maryland and Mandall Hygiene. I amd Memtal Hygiene is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	(Give	dent's Usual Occupation kind of work done during most o OO NOT use retired)	f working	6b. Kind of Busine	
Maryland 21215-0036	filed with al Hygier d other t event, th	Be	17. Father's Name (First, Middle, Last)	Sa.		s Name (First, Middle, Ma	Food Ind	ustry
aryla	hould be and Ment is marke sumatic	10	Samuel Werner 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number of	or Rural Route Number, C	City or Town, State,	Zip Code)
_	of Health of Health fitem 27 rother tra		Carol Craig 20a. Method of Disposition	20b. Place of Dispo	Mauldin Avenue	· · ·	Marylan Oc. Location - City	
Baltimore,	t. Page tment rtant: I		1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee	Ardent C	remation, Inc. 7 Name and Address of Facility	7-8-11 Marzullo F	Hanover,	
ñ	Depar Impor any ir		23a. Part 1. Enter the disease, or complications that cause	60	009 Harford Roa	d,Baltimore	,Marylan	
Ρ	nysician/ Medical		shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	ricula- Fil	or llahon	indiae of respiratory arres	*1	Interval Between Onset and Death
	Examiner	Je.	Sequentially list conditions, b.	s a consequence of):	Farehon			
70	and transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	s a consequence of:	Disease			
00	hysicial	dical	resulting in death) Last Due to (or as	der Cana	er			
Š Š	uean cernic	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
JS, P.O	to the tropping of wentuing tripstoan, the taw requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	ed by Pł	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in Part I.			e to the cause of death?
DIVISION OF VITAL RECORDS,	te has bee age 2 sho	Completed by				24a. Was an autopsy perform 1 \sum Yes 2	ed? prior	autopsy findings available to completion of cause of 1? Yes 2 \sum No
Vitai r	s certificate has t		25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	tient 2/SPER/Outpatie	26. Place of Death			
n or	ith. : After this e funeral d		27. Manner of Death 1 Natural 5 Pending (Month, Did Accident Investigation)	ury 28b. Time of		28d. Describe how		Jecny)
DIVISIO	s after des	Certificate:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, str tc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,		Rural Route Number,
- time Hoom	within 24 hours after death, To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of the conly one) 3 Certifying Nurse Practioner: To the	examination and/or inves	tigation, in my opinion, death occu	irred at the time, date and	place, and due to t	he cause(s) and manner stated.
	With Con		29b. Signature/and little of gertifier Tulm // // // // // // // // // // // // //	hmo	29c. License number D 005202	-	d. Date signed (Mo	0 0 1 1
			30. Name and address of person who completed cause of	death (Item 23a) (Type, F	DOOSZOZ Print) Over Sheef L	Salhaure Ma	yland 2	1225
	Stat Řegistra	-	31. Date filed (Month, Day, Year) 32. Project	rar's Signature	arkel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 22466 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ENRY 2:23A M **JOSEPH** WITTHAUER JR Medical 4a. Facility Name (if not institution, give street and number) 4c County of Death Examiner 4b. City, Town, or Location of Death Southmore Joseph Medical MUSORI Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 6. Sex 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 07/227 1930 ear 1 **XX**M 2 □ **F** MaryTand 80 Director 192-22-2905 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 Yes 2XXNo Maryland Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be n 21286 with 2 Southerly Court USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
YES 2 No Korea Black, White, etc þ ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify: If Yes, Give Year or Dates Specify: White Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Administration Manager Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Joseph Witthauer Mary Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Madge Court White Marsh, Maryland 21162 Son David Ireton Witthauer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial XX Cremation 3 Removal from State 07/13/2011 GreenMount Crematory Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ Adenocarcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Year Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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DHMH 17 Rev 7/2009

11-05001

Please Type or Print in Rlack Indelible Ink Figure All Copies Are Legible

Arlene Mae Windon	State of Marylar 1- For State Registrar	nd / Department of He Certificate of Dea	alth and Mental Hy	giene Reg. N	2811 22467
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Arlene Mae Windon			2. Date of Death Month Day July 4, 2011	3. Time of Death 1545 hrs
	4a. Facility Name (if not institution, give street end num Prince Georges Hospital Center ICU		v, Town, or Location of Death everly		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 6. Sex 7 1 1 M 2 F	J 1 1	nder 1 Year If Under 24Hrs. https://doi.org/10.1001/	8. Date of Birth (Mr March 8	M/DD/YYYY 9. Birthplace (State or Foreign District of Comby Lumbia
Aaryland 28a-f show any 1 at once. @ctor	Usual Residence of Decedent 10a. State 10b. County Pennsylvania Westmorelan 10e. Street and Number		Zip Code	Lion G	10d. Inside City Limits 1 X Yes 2 No itizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once. al Director	426½ Lehmer Street		5650		J.S.A.
fter death wi	1 Never Married 2 Married Armed Ford 1 Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates:	tes? If Yes, spending 2 No 1 Yes	ident of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin Completed by	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4)	during most of y		ed)	. Kind of Business/Industry Janufactureng
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than the event, the Medita To Be Complé	17. Father's Name (First, Middle, Last) Irving W. Windsor, Jr. 19a. Informant's Name/Relationship (Type, Print)	10h Mailing Adda	June Mil		en Surname) City or Town, State, Zip Code)
e, MD 21 t and 2 should Health and Mer item 27 is mar r traumatic ev	Raven GraWindon, Jr.	38 West	Fourth Avenue	,Latrobe,	Pennsylvania 15650
	20a. Method of Disposition 1	St. Mary's	7 -	11 - 11 La	atrobe,Pennsylvania
Baltimo permit. Page Department c Important: injury or ott	21. Signature of Funeral Service Licensee	6009	Harford Road,	Baltimore	neral chapel,P.M. e,Maryland 21214
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic	sed the death. Do not enter the mode (Free Morphine)	e of dying, such as cardiac or	respiratory arrest, s	chock, or heart Approximate Interval Between Onset and Death
	or condition resulting in death) Due to (or as a condition sequentially list conditions,				
ed nsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
execul an and al - tra	d. X UNPENDED AMENDED 2.3	3a,pt.II,27,28a-f	,per me,g917	7-28-11 sı	m
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transcription: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?	nt at time of death 5 Other (S	_		23d. Date of delivery Month Day Year
P.O. E res that the c signed by the be detached d by Phy	Part II. Other significant conditions contributing to c				co use contribute to the cause of death? No 3 Probably 4 V Unknown
Division of Vital Records, P.O. fal or Attending Physician: The law requires that the rape after death. 14 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly entification: To Be Completed by Pertification: To Be	Acquired Immunodeficier	ncy Syndrome(AIDS	S), Hepatitis C 26 Place of Death (Check o	- C	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
F Vital Rec Physician: The or this certificate ral director, page To Be Con	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 In	patient 2 ER/Outpatient 3	104	Home 5 Resi	dence 6 Other:
ion of Veath of Physics of After the funeral attion: Total	27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month, Death) 1 A Technology 1 A Tec	Day,Year)	1 ''	28d. Describe how i Unknown	injury occurred
Division o spital or Attending nours after death. neral Director: Aft filled in by the function:	3 Suicide 6 K Could not be	of Injury - At home, farm, street, fact Prince Geroge's I Center ICU	ory, office building, etc.	28f. Location (Stree or Town, State) Chever1v.	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner sta	of my knowledge, death occurred at examination and/or investigation, in			
Ne se se se	29b. Signature and title of certifier		O.C.M.E. OCME		d. Date signed (Month, Day,Year)
ち	30. Name and address of person who completed cause Theodore M. King, Jr., MD. Assistan	of death (Item 23a) t Medical Examiner 900 \	V. Baltimore Street, Ba	altimore, MD 21	1223
State Registrar		istrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar		aryland / I	Depar <i>Certii</i>	tment of Health	and Mental H	ygiene Reg. No. 2		
	Phys /Med Exam	dical	4a. Facility Name (If not institution,	give street and number)		(1)	b. City, Town, or Location	2. Date of D Month	eath Day	Year Oll 112A	
	Funera				e (In yrs. last birt	thday)	Baltimore City				
	Directo	r	218-60-9494 Usual Residence of Decedent 10a. State 10b. County	A W Z F	57	Yrs.	onths Days Hours	Min. (Month, D	av Year)	9. Birthplace (State or Foreig Country)unk	
the Mar	28a-f sl	Director	MD			imore				10d. Inside City Limits 1 XYes 2 □ No	
ath with	s 23a or ust be n		10e. Street and Number	ore St.			0f. Zip-Code 21202		10g. Citizen of V	Vhat Country?	
d 21215-0036 filed within 72 hours after cleath with the Mandond	It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E			Decedent of Hispanic Ors, specify Cuban, Mexica Yes 2X No Specify			e - American Indian, k, White, etc.	
Baltimore, Maryland 21215-0036	/giene. er than "natı , the Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) unk	College (1-4 or 5+	((Give kind	's Usual Occupation UT of work done during mos VOT use retired)	1k st of working	16b. Kind of B	usiness/Industry unk	
aryland should be file	of Health and Mental Hygi f Item 27 is marked other r other traumatic event, <u>tr</u>	To Be	17. Father's Name (First, Middle, Las 19a. Informant's Name/Relationship					er's Name (First, Middle			
e, Ma	Health ar em 27 is ither trau		Sharnett Thomps 20a. Method of Disposition		er		ddress (Street and Numb	er or Rural Route Numbe	er, City or Town,	State, Zip Code unk	
Iltimor	Department of Important: If It and Injury or o once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🕅 Other (Spec.	Min state	20b. Place of E cemetery,	cremator	y or other place)	Date		City or Town, State	
Balti	any any once		21. Signature of Funeral Service Licer Dayle A	1/0/4		l 6.	ne and Address of Facilit 55 W. Baltin	nora St. Dal	44	d MD 21201	
_ /M	/sician ledical aminer		23a. Part 1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	plic I ns that caused thone cause on each line. a	tiocel	t enter the	mode of dying, such as	cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
executed	physician and s the burial-transit	Examin	Sequentially list conditions, lany leading to mm. Jogause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last	b							
38760, ficate be ex	physicia s the bur	edical		.d							
30x 6		₹ 1	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 Ectop	oic pregnancy (specify)		23d. Date Monti		
cords, P	be d	2	art II. Other significant conditions of	intributing to death but n	ot resulting in th	ne underly	ing cause given in Part I.	23e. Did tob		ute to the cause of death? ☐ Probably 4\(\) Unknown	
I Re	cate has	De Completed	. Was case referred to medical examiner?				00 Pl	/	ed? dea	re autopsy findings available or to completion of cause of ath?	
n of \	er this ce	0	1 ☐ Yes 2 ☐ Mo	28a. Date of Injury	2 ER/Outpation		Othor	f Death (Check only one) ng Home 5 □ Residen	ce 6 Other	Specify)	
Division of Vita Hospital or Attending Physician: 24 hours after death.	completely filled in by the funeral	IIIIcanio	1 Natural 2 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year 28e. Place of injury - A building, etc. (Sp	Injury	y M	Work? 1 ☐ Yes 2 ☐ No		-	or Rural Route Number,	
Hospital of thours a	tely filled i		a. Certifier (check only 2 Medical Exami	ician: To the heat of		ath occurre	ed at the time, date and p	Chy or lown,	State)		
To the I	completely fi	29t	one) D. Signature and title of certifier	ner: On the basis of exan and manner stated.	nination and/or i		on, in my opinion, death		e and place, and	due to the cause(s)	
		30.	Name and address of parend who are	eao, MD			RE5-000	290	I. Date signed (M	onth, Day, Year)	
	State		Name and address of person who co Allison L. Tsao MJ Date filed (Month, Day, Year))		e, Print)	60	00 North Wolfe	St, Baltin	more, MD, 21287	
R	egistrar		JUL 1 4 2011	39. Registrar's Sig	S. par	de					

ORIGINIA

11-05136 Neil Wasserman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 State of Maryland? Department of Health and Mental Hygiene

leil Wasserman		amend #15 1- For State Registrar	ate of Maryla	ind919epa Ce	artifient of rtificate of	Health an Death	d Mental H		201	1 22469
Physicia Pedical Exami		Decedent's Name (First, Midd NEIL	WAS	SERMAN				2. Date of Deal Month July 9, 20	th Day Year	3. Time of Death 2331 hrs
		4a. Facility Name (if not institution 1305 E. Spring Mead		mber)		4b. City, Town, or Edgewood	Location of Deat	n	4c. County of I Harford	Death
Funeral Director		5. Social Security Number 220-40-7868	6. Sex	7. Age (In yrs. I		If Under 1 Yea Months Day) I _F	9. Birthplace (State or Foreign Country) MD
nd show any ice.	ŗ	Usual Residence of Decedent 10a. State 10b. County MD HA	RFORD	10c. City	, Town or Locati				•	10d. Inside City Limits 1 Yes 2 X No
MD HARFORD EDGEWOOD 100. Street and Number 10f. Zip Code 1305 E. SPRING MEADOW COURT 21040						040	10	10g. Citizen of What Country? USA		
MD 21215-0036 2 should be fited within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatie event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2	12. Was Dec	edent Ever in U prces? 2 No	13. Walf Y	s Decedent of His es, specify Cuban	panic Origin? (S , Mexican, Puerto	pecity Yes or No Rican, etc.)		American Indian, Black,
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed t	15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest grad	-4 or 5+)	during m	t's Usual Occupat ost of working life. AIL MERC	DO NOT use ret		16b. Kind of Busin	ness/Industry
21215-0036 ould be filed within 7 Mental Hygiene. I marked other than it event, the Medica	Be	17. Father's Name (First, Middle I SADORE 19a. Informant's Name/Relations	,,	WAS	SERMAN		HELEN		Maiden Surname)	GOODMAN
- P = B = F	۲	TODD WASSERM 20a. Method of Disposition		20b.	1250		BLUFFS			VA 23233
Baltimore, permit. Pages las Department of He. Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other S 21.	pecify:	om State	crematory or oth BETH JAC VESHEAR	ner place) COB ANSH CEMETER ame and Address	E Y 07/	11/2011	BALTI	IMORE, MD
Physician		23a. Part. Enter the disease, or	20000271	aused the death	890	OO REIST	ERSTOWN	ROAD, P	SON & BROIKESVILLE	E, MD 21208
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <u>Hyperte</u>		Atheros					Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate	b	consequence o						
xecuted n and ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence o	of):					
D, be e. siciar	edical	X UNPENDED	AMENDED 2			917 7–18	-11 sm			
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M		1 Live b 4 Pregn known 9 Unkno	ant at time of de wn	2 Fet eath 5 Oth	al death 3 [ner (Specify)	Ectopic pregna		23d. Date of de Month	Day Year
s, P.O. Lires that the signed by d be detach	2	Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	nderlying cause g	iven in Part I.			te to the cause of death? Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sted in by the funeral director, page 2 should be a base of the control of the funeral director.	Completed								sy pric	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital hysicians this certification	o Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Heapital	npatient 2	ER/Outpatient		of Death (Check Other Nursin		Residence 6	Other: Scene
ion of tending Pheath. tor: After the funeral	ation: 1	27. Manner of Death 1 X Natural 5 Pendent Investment		of Injury Day,Year)	28b. Time of Ir		y at Work? 'es 2 No	28d. Describe h	now injury occurred	
Division spital or Attentours after death	Certification	3 Suicide 6 Cou		e of Injury - At he	ome, farm, stree	t, factory, office b	uilding, etc.	28f. Location (S or Town, Si		or Rural Route Number, City
To the Hospital within 24 hours: To the Funeral completely filled	Medical	one) 2 Medical Exa	hysician: To the bes miner:On the basis o and manner st	of examination a		on, in my opinion,	death occurred a		and place, and due	to the cause(s)
9V 0	2	29b. Signature and title of certific	e Ha	Dai		29c. License O.C.N			29d. Date signed July 10, 2011	(Month, Day, Year)
pond		30. Name and address of person Carol Allan, MD As	who completed caus sistant Medical I		,	imore Street,	Baltimore, M	D 21223		
Sta	ate	31. Date filed (Month, Day, Year)	2011 32.6	gistrar's Signatu	1 hours	v.I				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RIVERVIEW NURSING FACILITY ESSEX BALTIMORE 7. Age (In yrs. last birthday) 81 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number - 28 - 6614 **Funeral** 1**X** M 2□ F Months Days Hours Min. 7-12-1930 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD Director ROSEDALE 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 PATAPSCO AVENUE 21237 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No If Yes, Give 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No WHITE Specify. Specify: ģ ¾☐ Widowed 4 ☐ Divorced Year or Dates 951-53 Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 LUBRICATION BETHLEHAM STEEL traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental F BERNHARDT W. ZYBELL, SR. HELEN V. CIOKA ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tran-WILLIAM ZYBELL, JR./SON 132 RODEO CIRCLE MIDDLE RIVER, MD Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 7-18-2011 BALTIMORE, 21. Signature of Funera 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: asn yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by ficate has been si 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No Division of Vital 1 ☐ Yes 1 Yes 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No after death Director: / 2 Accident investigation Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours a ca 29a. Certifier 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one)

29b. Signature and title of

ame and address of

the within ?

cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 6 2011[°] **Physician** 28 b810 Millie Alston /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 909 Johnson Street Salisbury 9. Birthplace (State or Foreign Country) SC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 – 13 – 1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 T F Months Days Hours Director 67 248-60-3180 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f showevent, the Medical Experience is using the notified at 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 909 Johnson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify SpecifBlack \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, In Me once. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping 8 Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Murray Osborne Lena B. Watts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Johnson Street, Salisbury, MD 21804 Carrie Campbell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Springhill Mem Gard 7-2-2011 Hebron, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 917 W. Isabell St. Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final No tostal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknoy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à cate has been signated by page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 1 □Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ne) Other: 4 Nursing Home Hospital: 1 Yes 2 No 5 Residence 6 ☐ Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Ceath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes **∠** Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 295. Signature and title of pertific 29d. Date signed (Month, Day, Year) HE POBOX1733 Solush

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

lichard	l Allen B	uck	er St 1- For State Registrar	ate of Maryla		artment of ertificate of		nd Mental		20 Reg. No.	11 22472
A 400 E	Physic		1. Decedent's Name (First, Midd						Date of De Month	eath Day Yea	3. Time of Death
	al Exam	iner	Richard All 4a. Facility Name (if not institution				b. City, Town, o	r Location of De	July 2, 2	4c. County of	1831 nrs
			St. Mary's County Hos		(11001)		Leonardtov		eu i	St. Mary	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea		_	Birth (MM/DD/YYYY	9. Birthplace (State or
. I	Director		217-02-9924	1XM 2∏F	4.5	5 Yrs.	Months Day	ys Hours 1	May May	7, 1966	Foreign Maryland Country)
	, a		Usual Residence of Decedent 10a. State 10b. County		Inc. City	, Town or Locati	00				10d. Inside City Limits
	d how a		Maryland	Mary's	Too. Only		micsvill	P			1 Yes 2 X No
	Maryland 28a-f she i at once	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	
	with the Maryland ns 23a or 28a-f she be notified at once	100	40680 Old Ho	rselanding	g Road		2065	9		United	States
	2 2 2	Funeral	11. Marital Status 1 Never Married 2 X M		edent Ever in U	I.S. 13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin?	(Specify Yes or Nerto Rican, etc.)	No- 14. Race White	- American Indian, Black,
	or dear			1 Yes	2 X No		Yes 2 X No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		White
	hours after death 'natural", or iter Examiner must	d by	15. Decedent's Education (Spec	or Dates:			res 2 No		of work done	Specify: 16b, Kind of Bu	
		lete	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during mo	st of working life	e. DO NOT use	retired)	Archite	ct of the
93	led within 72 Hygiene. other than ' the Medical	Completed	10			Mainte	enance M				Capital
21215-0036	al Hygi	Be C	17. Father's Name (First, Middle, Jay B. Buck	•						, Maiden Surname)	
	ould be fil Mental F marked ic event,	To B	19a. Informant's Name/Relations			19b. Mailing	Address (Stree		ret A. I	umber, City or Town	n, State, Zip Code)
A	Pages 1 and 2 shoul ment of Health and N tant: If item 27 is m or other traumatic		Heather D. Bud	ckler/wife		PO Box	165, C	harlott	e Hall,	MD 20622	
Je,	of Hea		20a. Method of Disposition 1 ABurial 2 Cremation	3 Removal fro		Place of Disposi crematory or oth	tion (Name of ce er place)	metery, J	uly 8,	20c. Location -	City or Town, State
Baltimore,	ment tant:	Ш	4 Donation 5 Other Sp	ecify:		l Faith	Episcop	al Chur	ch 2011	l Mechan	icsville, MD
Ba	permit. Pages I Department of I Important: If injury or other	1	21. unature of Funeral Service		100817						F.H., P.A.,
	ysician		23a. Part I. Enter the disease, or	complications that ca		. Do not enter th	e mode of dying,	such as cardia	c or respiratory a	rest, shock, or hea	Hall, MD 2062.
	Medical caminer		failure. List only one cause Immediate Cause (Final disease	on each line. a. <u>0xycod</u> c	ne Into	oxicatio	n				Between Onset and Death
. - ^			or condition resulting in death)	Due to (or as a							
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	ef):					102
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence o	ıf)·					
	ecuted and transit	_	events resulting in death) Last	_ d							
Ć.	be exe ician urial -	dica	X UNPENDED	AMENDED 2	3a,27,2	28a-f,pe	r me,g9]	18 8-2-1	ll sm		
Box 6876(eath certificate b attending physi for use as the bu	cian/Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o	utcome of preg		al death 3	Ectopic preg	manov	23d. Date of o	delivery Day Year
39 ×	eath cert attendin for use a	icia	past 12 months?	4 Pregna	ant at time of de	oth -	aldeath 3 er (S <i>pecify)</i>	Ectobic bies	griaricy	MOTH	Day real
8	he dea y the a hed fo	Physi		nown 9 Unknow					[00 B:		
Division of Vital Records, P.O.	10 the Hospital or Attending Physician: The law requires that the death certificate within 24 bours after death. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	ğ	Part II. Other significant conditi	ons contributing to	death but not re	esuiting in the ur	nderiying cause g	jiven in Part I.			oute to the cause of death? Probably 4 Unknown
Sp.	w require ts been si should b	Completed							24a. Wa	s an 24b. W	Vere autopsy findings available
ō.	te has ge 2 st	틸							perf	ormed? d	rior to completion of cause of eath?
<u> </u>	ysician: The l his certificate l director, page	B C	25. Was case referred to medical	- L				of Death (Che	1 Yes	2 No 1	Yes 2 No
Z Z	hysicii this ca al direc	P	examiner? 1 Yes 2 No	Hospital: 1 In	patient 2 🗹	ER/Outpatient	3 DOA	Other ₄ Nur	sing Home 5	Residence 6	Other:
jo.	ding F		27. Manner of Death 1 Natural 5 Pend		Day,Year)	28b. Time of In	·	ry at Work?		how injury occurre	
Sio	Atten r death rector: by the	icati	2 X Accident Inves	tigation 280 Place		fd 5:19 ome, farm, street		res 2 No	7	t snorted	
ē.	pital or At ours after d ieral Direct filled in by	Certification:		not be 256. Flace nined (Specify)	hom		, ractory, onice p	diding, etc.	or Town,	State)40680 0 nicsville	r or Rural Route Number, City ld Horse Landing Rd Md
ı	To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledg	ge, death occurr	ed at the time, da	ate and place, a	nd due to the cau	use(s) and manner	as stated.
	To the Howithin 24 h To the Fur completely	Medical		niner:On the basis of and manner sta	examination a ated.	nd/or investigation			d at the time, date		
		2	29b. Signature and title of certifier	0 11	12		29c. Licens				d (Month, Day, Year)
		1	30. Name and address of person	who completed cause	of death (Item	23a)	0.0.1			July 3, 201	•
			Jack Titus MD. Dept	uty Chief Medica			altimore Stre	et, Baltimoi	e, MD 21223	3	
	St Regist	ate	31. Date filed (Month, DayYes?)	2011 37 Reg	istrar's Signatu	. par	W				

			For State Registrar	tate of Maryland /		icate of E	eath	F	Reg. No 2011	22473
i	Physicia	n/	1. Decedent's Name (First, Middle, Last) Norah Francis Brere	ton				2. Date of Dea	th Day Year	3. Time of Death
افريد.	Medic Examin		4a. Facility Name (if not institution, give street		4b	o. City, Town, or	Location of Death	June 27	4c. County of Dea	
بمرديه			Sacred Heart Home			<u> </u>	sville		Prince (
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	2 🖾 F 7. Age (In yrs. last bi		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 24)	Year) C	irthplace (State or Foreign ountry) eland
	ind show at	ŏ	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Locatio	on				10d. Inside City Limits
	Maryla 28a-f s otified	Maryland Anne Arundel Annapolis								1 ☐ Yes 2 🛣 No
	ith the	ralD	10e. Street and Number 1199 Southview Driv	Δ	1	Of. Zip Code	409		10g. Citizen of What C Irelar	
	items ?	Funeral Director	11. Marital Status 12. V	Was Decedent Ever in U.S.	13. Was	Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	nerican Indian,
036	s after or ral", or Examir	ed by	1 Never Married 2 Married	l ☐ Yes 2 ☒ No f Yes, Give ∕ear or Dates.		Yes 2 No		, , , , , ,	Specify: Wh	
15-0	72 hour "natu edical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working							s Industry
212	within giene. er thar		Elementary/Seconday (0-12)	College (1-4 or 5+)		oT use retired) se's Ai	.de		Hospital	Nurse's Aide
Maryland 21215-0036	ntal Hy ed oth event:	To Be	17. Father's Name (First, Middle, Last) John Walsh				18. Mother's Name		*	
aryl	hould thank Me s mark		19a. Informant's Name/Relationship (Type, P	rint) 15	9b. Mailing Ad	ddress (Street a			City or Town, State, 2	ip Code)
დ ზ	and 2 s Health a em 27 i		Catherine E. Sowers 20a Method of Disposition						is, MD 214	
mor	Dage 1 and the control of H		1 🛣 Burial 2 ☐ Cremation 3 ☐ Rem- 4 ☐ Donation 5 ☐ Other (Specify)	como	of Disposition tery, cremator ton Nati	niar athor plac	etery 8/3/	2011	20c. Location - City of Arlington,	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	14	22. Na	ame and Addres	s of Facility			imore Avenue
ı			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can	ons that caused the death. Do						Approximate Interval Between
إاس	h, sician/ Medical		Immediate Cause (Final	Myocardial In		.on				Onset and Death 5 Months
	Examiner			Due to (or as a consequence Hypertension	e of):					Years
-	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence	e of):					
	sate be executed physician and the burial-transit		that initiated events c. — resulting in death) Last	Due to (or as a consequence	e of):					
760	cate be physic s the bu	edical	d							
29 ×	ath certific attending p for use as	Physician/M		f yes, outcome of pregnancy						
Box	e deat the att	ysici	1 Ves 2 X No		ath 3 🗌 Ect	topic pregnanc	y		23d. Date of d	
	٦ × ا		g 🗌 Unknown	Pregnant at time of death		topic pregnanc her (specify)	у		23d. Date of d Month	lelivery Day Year
, P.O	es that the igned by be detacl	þ	g Unknown Part II. Other significant conditions contributions	☐ Pregnant at time of death ☐ Unknown uting to death but not resulting	n 5 🗆 Ott	her (specify)			Month bacco use contribute	Day Year to the cause of death?
ords, P.O.	requires that the de been signed by the should be detached	þ	g 🗌 Unknown	☐ Pregnant at time of death ☐ Unknown uting to death but not resulting	n 5 🗆 Ott	her (specify)			Month bacco use contribute fes 2 🖾 No 3 🗆	Day Year to the cause of death? Probably 4 Unknown autopsy findings available
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Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacted.	Medical Certificate: To Be Completed by	Part II. Other significant conditions contributed Chronic Renal Failuted Arthritis 25. Was case referred to medical examiner? 1	tal: 1	Outpatient 3 Description of the under of the	26. Place of the state of the s	en in Part I. ace of Death (Check r. 4 📉 Nursing Ho at ? Yes 2 🗆 No date and place, ar n, death occurred ar time, date and place number	24a. Was a autop performent of the cate of	Month bacco use contribute fes 2 M No 3 an	Day Year to the cause of death? Probably 4 Unknown autopsy findings available to completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the completion of cause of the ca

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Box 31 - CZ State of Maryland / Department of Health and Mental Hygiene PerHealth Department Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:30 рм 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution Examiner give street and number) Washington 570 Jefferson Street Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** July 29 Days Hours 1 🗆 M 2 🗶 F 1949 Maryland 61 Director 212-58-7638 Usual Residence of Decedent 28a-f show 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director Hagerstown 1 X Yes 2 No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral USA 21740 570 Jefferson Street items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. ō þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) State Hospital Nursing Assistant 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Virginia Keedy Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 570 Jefferson Street, Hagerstown, Maryland 21740 Gerald Bernhisel - Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Williamsport, Maryland 7/7/2011 Greenlawn Mem. Park Signature of Funeral Service Licensee MINNICH FUNERAL HOME 2) Name and Address of Facility 415 E.Wilson Blvd., Hagerstown, Md. 21740 the death. Do not enter the mode of dying 23a. Part 1. Enter the disease, or complications that caus Interval Between shock, or heart failure. List only one cause on eag Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and attending physician Physician/Medical Box 68760 the IE EEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐼 No Month Year be detached for 5 Other (specify) Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy has death? 1 Yes 2 No certificate 25. Was case referred to medical completed filled in by the fun ral director, 26. Place of Death (Check only one) Division of Vital Be examiner? 1 \square Yes Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after de th. Directo: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural or Attending 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 29b. Signature

State

Registrar

Date filed (Month, Day,

5

al Campus Rd

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

		-	For State of Mary State Registrar	-	artment of He tificate of De		ientai mygi Re	ene 91	1 22475
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Menth	1	3. Time of Death 9:18 pM
	Medic Examin		Mary Arlila Burns 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	mig	4c. County of	
أمر			Meritus Medical Center		Hagerst			Washin	
	Funeral Director		216-30-2818 1 D M 2 🔀 F 7	yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, March 28,	^{Ye} 1934 F	9. Birthplace (State or Foreign Country) rederick, MD
	show at	5	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla 28a-f s tified	rect	MD Washington	Hagers	town				1 🕅 Yes 2 □ No
	a or 2 be no	a Di	10e. Street and Number		10f. Zip Code		11	0g. Citizen of Wh	nat Country?
	th wit ms 23 must	Funeral Director	750 Dual Highway 11 Marital Status 12. Was Decedent Ever	in II 6 12 1	21740		cify Yes or No-	USA	- American Indian,
0	er dea or ite niner	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Was Decedent of Hisp f Yes, specify Cuban,		Rican, etc.)		White, etc.
Ř O	ırs aftı ural", IExar	ted k	3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	1 ☐ Yes 2X No	Specify:		Specify:	White
<u>5</u>	72 hou n "natu ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupat kind of work done du	ion ring most of worki	ng	16b. Kind of Bus	iness Industry
72	within 7 giene. er than t, the M		Elementary/Seconday (0-12) College (1-4 or 5+)	O NOT use retired) Giver			In Home	Health Care	
g	双介書を	Be c	17. Father's Name (First, Middle, Last)	,		18. Mother's Name			
<u>8</u>	: should be file h and Mental I 7 is marked o rraumatic eve	욘	Roger Vernon Wiles				iola Ram		
Mai			19a. Informant's Name/Relationship (Type, Print) Roger G. Wiles / Brother	4.1	ng Address (Street an Harmony I				
<u>ē</u>	and Hea tem		20a. Method of Disposition	20b. Place of Dispo	sition (Name of				City or Town, State
Ē	Page 1 ment of ant: If it		1 Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify)		natory or other place) irch Cemeter		3/2011	Myersvil	lle, MD
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If ii any injury or o		21. Signature of Funeral Service Licensee	22		of Facility Gen			Funeral Home
	•	H	23a. Part 1. Enter the disease, or complications that caused the						Approximate Interval Between
u F	trysician/	0 /	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	to m	uneandic	al in	1 LONG	hou	Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a co	nsequence of):	yseardic teu sio				
		ier	Sequentially list conditions, b. Due to (or as a co	FY SC)	100 710	N			
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	,					
	exectian an	EX	resulting in death) Last Due to (or as a co	onsequence of):					
200	cate be executed physician and the burial-transit	edical	d						
687	ding partific	n/Me	IF FEMALE: 23c. If yes, outcome of p					23d. Date	of delivery
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at tirr		Description of the control of the co			Mont	
0	of the contraction of the contra		9 Unknown Part II. Other significant conditions contributing to death but n	not resulting in the u	ınderlying cause give	en in Part I	23e Did toh	acco use contrib	oute to the cause of death?
ω, σ,	res tha signed	d by	Lune Concor, S	20011		(monio			3 N Probably 4 □ Unknown
ord	requi	lete	de forto	1			24a. Was ar		ere autopsy findings available
Šeč	he law te has age 2	Completed	- HEUCE ZELLE GA	elure,			autops perform 1 \sum Yes 2	ned2 de	rior to completion of cause of eath?
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<u></u>	Physic this or	၉	1 Yes 2 No Hospital: 1 Inpatient 27. Manger of Death 28a. Date of injury	2 ER/Outpatier		4 U Nursing Ho	ome 5 Reside		
n o	ding th. After funer	cate	1 Natural 5 Pending (Month, Day, Ye 2 Accident Investigation		work?		28d. Describe 110	w injury occurred	·
Division of Vital Records, P.O.	- Atter er dea rector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
2	iital or urs aft ral Dir lled in								
	Hosp 24 hol Fune eted fi	edical	29a. Certifier (Check 2 Medical Examiner: On the best of my only one) 3 Certifying Nurse Practioner: To the bes	nination and/or inves	stigation, in my opinion	, death occurred a	t the time, date an	d place, and due	to the cause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 \(\subseteq\) Certifying Nurse Practioner: To the bes 29b. Signature and title of certifier	t of my knowledge,	29c. License				(Month, Day, Year)
	C2-		had id Colorend)	D	0063	233	07/	03/2011
	3		30. Name and address of person who completed cause of death			~71	0	blo on	2174
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's		BOC N	orthean	1 Hue	inger:	1 Powa PD
	રાટ Registr		JUL 0 x 2011 2 men	J B. A	acked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{2}\underline{011}$ Physician/ Month Rae Elizabeth BARTON 29 3:45 p. ^M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Washington 427 Rhode Island Avenue Hagerstown Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth h 18 Min 1 M 2 X F 213-42-1598 Maryland Director 68 1943 March Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1XXYes 2 No Maryland Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21740 USA 427 Rhode Island Avenue r than "natural", or items the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates white 1 ☐ Yes 2X No Specify "natural", Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 her own home homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Harold E. Cross Charlotte G. Recker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Leonard W. Barton - Husband 427 Rhode Island Avenue, Hagerstown, Md. 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State 7/6/2011 Hagerstown, Maryland Cedar Lawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME E.Wilson Blvd., Hagerstown, Md.21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Due to jor as a consequence of cause. Enter Underlying sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?
1 Yes 2 No Day signed by the a g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ I or Attending Physician; The law requires t after death. Director: After this certificate has been sign 2 No 3 Probably 4 Unknown cate has been siç ; page 2 should b Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death?
1 Yes 2 No Yes 2 To the Hospital or Attending proystoram, within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, f 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🖭 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

JW-6

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31. Date filed (Monti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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.30.11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 1 22477 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 4:50PM Peter Francis Bryan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Meritus Medical Center <u>Hagerstown</u> 8. Date of Birth (Month, Day, Year) Oct. 15, 1933 9. Birthplace (State or Foreign Country) Mary Land Age (In yrs. last birthday Year If Under 24 Hrs. **Funeral** Hours Director 212-34-3835 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 **X** Yes 2 □ No Washington Maryland Hagerstown 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 13120 Blue Ridge Road 21742 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status was becedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates<u>1956—1958</u> Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Treasurer Shoe Manufacturer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Alva Jean Pettigrew Daniel Joseph Bryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Odenton. MD 21113 <u>Jennifer A. Bryan, daughte:</u> 2632 Summer Breeze Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 6/29/2011 Donation 5 Qther (Specify) Hagerstown Crematory Hagerstown, Maryland Signature Juneral Service Licens 22. Name and Address of Facility AK Coffman Funeral Home, Inc. st au 21740 40 East Antietam Street, Hagerstown, Maryland 23a, Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of): Examine Physician/Medical

Physician/ Medical Examiner

Certificate: To Be Completed by

Medical

attending physician and for use as the burial-transit been signed by the has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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Sequentially list conditions, it any to the time of the cause. Enter Underlying Cause (Disease or linjury	Due to or as a consequente of:								
that initiated events resulting in death) Last	Due to (or as a consequence of):								
	d								
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		topic pregnancy her (specify)		23d. Date of de Month	ilivery Day Year				
Part II. Other significant conditions co	ontributing to death but not resulting in the under	lying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?				
Chyonic Ob	structive pulmo	nary diseas	e 1 □ Yes	2 No 3 □ F	robably 4 🗆 Unknown				
Dementia,	ţ		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of				
25. Was case referred to medical		26. Place of Death (Chec							
examiner? 1 Yes 2 No	Hospital:	☐ DOA Other: 4 ☐ Nursing Ho	ome 5 Residenc	ce 6 Other (Spec	cify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how	injury occurred					
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,				
(Check 2 Medical Exami	sician: To the best of my knowledge, death occu iner: On the basis of examination and/or investigati se Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.				
29b. Signature and title of certifier	(29c. License number	290	d. Date signed (Mont	h, Day, Year)				
Mad lich be	hmod	D00632	33	06/23	2/2011				

State Registrar

TIN-10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 23.2011 Physician/ 8:10A BAILEY JEAN BRENDA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (*ln yrs. last birthday*) 48 Yrs. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Months 1 M 2XX Nov 19ay, Year 962 Maryland 215-86-5080 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2x1xNo New Market Maryland | Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21774 USA 5708 Kent Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces ☐ Yes 2 🔀 No ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: white If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) J P Morgan Chase Customer service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be fill thent of Health and Mental tant; If item 27 is marked ည Catherine Eleanor Bell Charles Lewis Dodson, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5708 Kent Drive, New Market, Maryland James Bailey - husband other Important; If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial 20c. Location - City or Town, State 20a. Method of Disposition Date 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State 6-29-2011 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sarature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence cause. Enter Underlying Cause (Disease or linjury • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Exam attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? Completed by 4 💢 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy perform Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completed filled in by Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2

State Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

egistrar's Signature course

Laki uova 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d, Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year John G. Bozman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Peninsula Regional Medicul Conta alisbun VICOMIC If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Days Maryland Director 212-40-8629 68 08/03/1942 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director Maryland Salisbury Wicomico 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a 713 Madison St. 21804 USA 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Coast Year or DatesGuard 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Reporter/Editor Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William R. Bozman Susie Moore permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Bozman/spouse 713 Madison St., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 6/29/2011 Salisbury, MD Signature of Funeral Service License 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Small bowel Ischemia Medical Due to (or as a consequence of) Examiner DIFF Colit Sequentially list conditions, Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Acure Myocardia death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown P.O. I To the Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 No 1 Tyes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director; A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number aza 068222 06/28/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Carroll 5t. 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 22480 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 CAROLYN LEE M. BURROWS JÜLY 8 6:51 p_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Chestertown Kent Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours 1 🗆 M 2 🔀 F March 23 213-42-0317 1942 Maryland 69 **Director** Usual Residence of Decedent Show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No Oueen Anne's Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3123 Millington Rd. 21651 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black White etc δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Grain Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ C. Olin Powell Edna Comegys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Burrows (Husband) 3123 Millington Rd. Millington, MD. 21651 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Kennedyville Cemetery 7/14/11 Kennedyville, MD. 4 Donation 5 Other (Specify) of Funeral Servic Sino Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sk, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Ph, sician/ disease or condition resulting in death) uns hre ni C Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 N 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

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the

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Bruce Obenshain, M.D.

4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

251 S. Bohemia Ave. Cecilton, MD. 21913

29d. Date signed (Month, Day, Year)

		1 - State of Maryland / State of Maryland / State	Department of He			ene g. 2011	22481
Physicia	ın/	Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
Medic	al	John Douglas Cross, Jr 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Lo		July	Day 2011 4c. County of Death	9:52 a M
Examin	er	28885 Lockes Hill Road	Mechani			St. Mary	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bird	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
Director		217-42-1892 68 Usual Residence of Decedent	Yrs.		(Month, Day, Y 06/25/1	943	Maryland
and show 1 at	ō	10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
Maryl 28a-f otifie	irec		nanicsville				1 Yes 2 X No
th the 3a or t be n	al D	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Cou	ntry?
ath wi ems 2 r mus	Funeral Director	28885 Lockes Hill Road 11. Marital Status 12. Was Decedent Ever in U.S.	20659 13. Was Decedent of Hisp	panic Origin? (Spec	ify Yes or No-	USA	can Indian.
tter de tor its	by F	Armed Forces? 1 ☐ Never Married 2 🏿 Married 1 ☐ Yes 2 🛣 No	If Yes, specify Cuban,	Mexican, Puerto R	lican, etc.)	Black, White,	etc.
OO3 ours at ttural" al Exe		3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 Yes 2 X No				ite
72 hc n 72 hc an "na Medio	Completed	(Specify only highest grade completed)	. Decedent's Usual Occupation (Give kind of work done during) (ife. DO NOT use retired)		g 1	6b. Kind of Business Ir	ndustry
212 withir giene giene her tha		Elementary/Seconday (0-12) College (1-4 or 5+) 5	School Teache	r	В	oard of Ed	ucation
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	1	8. Mother's Name			+h
iryla buld b id Mer mark matic	-	John Douglas Cross 19a. Informant's Name/Relationship (Type, Print) 19b	o. Mailing Address (Street and	Kathlee			
Ma d 2 sha alth ar 127 is er trau		1	8885 Lockes H			-	
A			f Disposition (Name of ry, crematory or other place)	Da	ate 2	0c. Location - City or 1	own, State
Baltimore, Dermit. Page 1 and Department of Hea Important: If item any injury or other		4 Donation 5 Other (Specify)	aith Episcopa		6/2011	Mechanics	
Baltimo		21. Signature of Funeral Service uses le	22. Name and Address Mattingley—P.O. Box 2	of Facility -Gardiner 270, Leon	Funeral ardtown,	Home, P.A MD 20650	١.
		23a. Part . Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.					Approximate Interval Between
Phylician Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the conse	MA OF	LUNG			Onset and Death
Examiner		Due to (or as a consequence of the control of the c		BONE			17km
	iner	Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying	.,	0 V / C			
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ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of	ot):				
760 icate b g physics s the b	ledic	d					
certifica	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	n 3 ☐ Ectopic pregnancy			23d. Date of deli	very
Records, P.O. Box 687 The law requires that the death certifica ate has been signed by the attending plage 2 should be detached for use as t	Physician/Me	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \) Unknown	5 Other (specify)			Month	Day Year
P.O. that the ned by the detach		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S, F Lires the signer of signer of signer of signer of the control	d by				1 🗆 Yes	2 □ No 3 🔀 Pro	obably 4 🗌 Unknown
yord w request seeming the see	plete				24a. Was an	24b. Were auto	opsy findings available ompletion of cause of
/ital Reco sician: The law I certificate has be irector, page 2 s	Completed				autopsy perform 1 \sum Yes 2		
ital ician: certific ector,	Be	25. Was case referred to medical examiner?	26. Place	e of Death (Check	only one)		
Phys Phys	은 :	1 Inpatient 2 ER/Ou 27. Manner of Death 28a, Date of injury 28b, 7	itpatient 3 DOA 28c. Injury a		ne 5 🗷 Residen 8d. Describe how	ce 6 Other (Specification)	ý)
on C anding ath. r: Afte	icat	2 Accident Investigation	njury work?	es 2 🗆 No	2000112011011	,a., accarres	
Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been sig ed in by the funeral director, page 2 should b	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa bullding, etc. (Specify)	rm, street, factory, office	2	8f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/o	death occured at the time, do	ate and place, and death occurred at t	due to the cause	(s) and manner as stat	ed. ause(s) and manner stated.
o the l ithin 2 o the l	M	only one) 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifier	ledge, death occurred at the ti	ime, date and place	, and due to the ca	ause(s) and manner as s	tated.
FSFO		Most of Bauer mo		4168		7-5-1	
eme		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Three Notch 1	Rd Mack	anicevi	11e. Mn 20	659
Stat	ie	31. Date filed (Month, Day Year) 32. Fegistrar's Signature		na., rieci	IGHTCSAT	TTE, ED ZU	
Registra	ar	JUL 0 5 2011 Janua B.	- Auri				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	ľ	For State Registrar			iai yiai i		tificate of E			eg. \20		22482
Physicia Medic		1. Decedent's Name Berkley		,					2. Date of Deat Month June 30	Dav	Year	3. Time of Death 3:19 a. ^M
Examin	er	4a. Facility Name (if r 11510 Ho		ve street and number)				Location of Death		4c. County	of Death	
Funeral		5. Social Security Nu	imber 6.			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		g. Birth	place (State or Foreign
Director		219-14-8 Usual Residence of D			85	Yrs.			(Month, Day, Aug. 1	1925	(ohio
ryland i-f shov ied at	Director		10b. County		10c. City	, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 X No
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th with ns 23a must b	Funeral	11510 Hop	ewell R				2174			U		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Industriat: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces? 1				ispanic Origin? (Spe n, Mexican, Puerto Specify:			ck, White,	can Indian, etc. ite
72 hou n "natu ledical	nplet	(Spec	15. Decedent's cify only highest	Education grade completed)		(Give		ation during most of worki	ing	16b. Kind of B	usiness Ir	ndustry
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e filed ntal Hy ed oth event	To Be	17. Father's Name (F		t)				18. Mother's Name		laiden Surnam	e)	
ould b nd Mer mark matic		Walter 19a. Informant's Nar		(Type, Print)		10h Mailir	an Address (Street	Emma Tri	*	City or Town	State Zin	Code
nd 2 sh ealth ar n 27 is er trau			· ·	ad - Wife		1		1 Road, H				
ge 1 ar of He in iter or oth			Cremation 3	☐ Removal from State	e c	emetery, cren	sition (Name of natory or other plac	e)		20c. Location	- City or T	Town, State
nit. Pa bartmer cortant injury		4 ☐ Donation 21. Signature of Fundamental Control of Fundamental C			Ced		n Mem. Pa		NNICH FU			wn, Maryland
Dep Imp any		174	SI II	Y /her	nue	_		son Blvd.				and 21740
Physician/ Medical		23a. Part 1. Enter th shock, or heart Immediate Cause (F disease or condition resulting in death)	t failure. List only Final	plications that cause one cause heach lin	ie. JUHA	y An	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	//	Approximate Interval Between Onser and Death
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ed nsit	Examiner	if any, leading to impose cause. Enter Underly Cause (Disease or ii	mediate lying	Due to (or as	a consequ	ience of):					6,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	that initiated events resulting in death) Li		C. Due to (or as	a consequ	ience of):						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent p in the past 12 m		23c. If yes, outcome			Ectopic pregnanc	ev ev		23d. Da	ate of deli	
the deat by the at ached fo	hysic	1 Yes 2 Unknown		4 Pregnant	at time of d	death 5	Other (specify)			Mo	onth	Day Year
quires that an signed to detail		Part Other signific	cant conditions	contributing to death	but not resi	2 · C	HAONIC	ver in Part I. () NEY	23e. Did tob			the cause of death?
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certific rector,	Be	25. Was case referred examiner? 1 Yes 2		Hospital:			_ Oth	ace of Death (Check	k only one)			
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tendin death. tor: Aft the fur	Certificate	1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigat 6 ☐ Could not	on he		injury		Yes 2 ☐ No				
ital or At urs after (ral Direc lled in by		4 Homicide	determine	building, et	c. (Specify,)	eet, factory, office		28f. Location (St. City or Town	, State)		
the Hosp nin 24 ho the Fune npleted fi	Medical	(Check 2 only one) 3		nysician: To the best o miner: On the basis of urse Practioner: To the	examinatior	and/or inves	tigation, in my opinio	on, death occurred at	t the time, date an	d place, and du	ie to the c	ause(s) and manner stated.
o o o		29b. Signatur Ang	te/of certifier	Francy 1	PHUSI	CIAN	29c. License	e number	2	9d. Date signe	30/	Day, Year) Z0//
571114		30 Name and address	s preson wh	ompleted cause of	death (Item	23a) (Type, F	B. Ave.	STC 101	HARLED	Toun!	111	2/747
Stat	te	31. Date filed (Month)	, Pay Year	2011 32 Bagisti	rar's Signat	ure 1	10 1100	10.01-1	HAROLL	i was o	HILLO	- 1 - 1 -

11-04784 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Cosens, Sr. State of Maryland / Department of Health and Mental Hygiene 22483 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 27, 2011 **Medical Examiner** 1056 hrs Kenneth Cosens, Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12654 McDade Road Washington Hagerstown 5. Social Security Number 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Director 220-26-5958 1 X M 2 F 79 Nov 16, 1931 Country) Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No Maryland Washington Hagerstown permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 12654 McDade Road 21740 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married f Yes, Give Yaar or Dates: 3 X Widowed 4 Divorced 1 Yes 2 No specify: Specify: White 台 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 10 Retail Service Repair 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) å Charles Howard Cosens Jane Corinne Muck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen C. Talbert/daughter 214 Graystone Drive Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/01/2011 Boonsboro, Maryland 4 Donation 5 Other Specify: Mt. Lena Cemetery 21. Signature of Funeral Sar 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart the line. Approximate Interval **Physician** Between Onset and List only one cause on each line. /Medical Death e Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IE EEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 趸 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an eutopsy prior to completion of cause of performed? page 2: death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes ၉ 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject shot self 1 Natural FOUND: 5 Pending 1 Yes 2 ✔ No death. filled in by the Jun 27, 2011 1050 hrs 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be or Town, State) 12654 McDade Road , Hagerstown, MD determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 241 Cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 28, 2011

JW-5

State Registrar DHMH 17 Rev 1/2001

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Dale Ε. Dement 24 201 Year Medical June 4:29 a.M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 45136 Andover Estates Road Valley Lee St. Mary's **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 05/23/1954 g. Birthplace (State or Foreign 1 XM 2 D F **Director** 217-66-0662 57 Maryland Usual Residence of Decedent show filed within 72 hours after death with the Maryland 10a. State 10b. County Director 10c. City, Town or Location "natural", or items 23a or 28a-f s edical Examiner must be notified 10d. Inside City Limits St. Mary's Valley Lee 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45136 Andover Estates Road 20692 Unites States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Completed 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Civil Servant Be U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert C. Dement Margaret Clarke Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally S. Raley/Sister 18987 Three Notch Road, Lexington Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Charles Mem. Gardens 06/29/2011 Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A.

Edward N. Brinsfield Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 21. Signature of Euro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Small Cell Lung Cancer disease or condition resulting in death) Medical Months Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last ending physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery ρ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation Completed 1 Yes 2 No 3 Probably 4 M Unknown page 2 s 24a. Was an ate has 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 🕱 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 X Natural 28d. Describe how injury occurred 5 Pending (Month, Day, Year) after death

Director: A
d in by the f Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be in 24 hou... the Funeral Direc-28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires within 24 ho

To the Fune
completed f

State Registrar

attending

29c. License number D0055682

★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

6/24/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 23130 Moakley St., Leonardtown, Maryland 20650

Thomas M. Wilkinson, 31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature and talle of certifier

for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month 1023 Dale, Sr. George Edward 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5A413841M HICOMICO 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 1**₹** M 2 □ F Days June 7, 1933 Min 220-28-4913 Marvland Yrs. Director 78 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location aţ 10a. State 10d. Inside City Limits Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 Yes 2 X No Maryland Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7218 Shockley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1953-1955 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tyson's Poultry truck driver other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Ida Mae Shockley permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. George Henry Dale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7218 Shockley Road, Snow Hill, MD 21863 Addie M. Dale/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Friendship UMC Cem. 6/26/2011 Snow Hill, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD Signature of Funeral Service Licenses al JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examir and -tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ned by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 Yes ☐ Accident Investigation 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the land within 2 only on 99c. License number 29b. Signature 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2

Certificate of Death

DHMH 17 Rev 7/2009

NP

Registrar

State

30. Name ar

N 28

rocomoke

person who completed cause of death (Item 23a) (Type, Print)

06-27-2011

21851

WD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7:35 Cecil Jennings Davis June 28, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Foxchase Nursing Home Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Ye Aug. 10, 9. Birthplace (State or Foreign 1 M 2 X F Lynchburg. Year) 035-20-6368 84 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 No Prince George's Hyattsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6700 Belcrest Road 20782 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Divorced If Yes Give Specify: White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accounting Technician Veterans Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dillard Jennings Gertrude Ann Redford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Marie Linkins / Friend 201 Argent Way, Bluffton, SC 29909 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 7/8/2011 Clinton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Ray Kogow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest disease or condition resulting in death) Due to (or as a consequence of) Liver Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or linjury that initiated events Hypertension Due to (or as a consequence of) resulting in death) Last Anemia IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

28a-f show

death with the Maryland

within 72 hours after

should be filed

1 and 2 s of Health item 27 i

permit. Page 1
Department of I
Important: If it
any injury or o

Baltimore, Maryland 21215-0036

and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical Completed by Be 25. Was case referred to medical 잍 27. Manner of Death Certificate:

Medical

examiner?

1 X Natural

☐ Accident

4 Homicide

only one) 29b. Signature and tigle of certifier

Suicide

2 🔀 No

5 Pending

Investigation 6 Could not be

determined

4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No

D67092

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed'

23e. Did tobacco use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

June 29, 2011

1 Tes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of

1 Yes 2 No

🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Weihan Wang, 2015 East-West Highway, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) JUL 0 1 2011

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. mend #2 Per PHY #12 Per PHY State of Maryland / Department of Health and Mental Hygiene - State amend items 5,12 per fh g918 8-30 de Death 29 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A^{M} 2011 11:45 Charles Ellis Daniel, Jr. June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 6000 Quintana Street Riverdale Prince George's 8. Date of Birth (Month, Day, Year June 26, 9. Birthplace (State or Foreign Country)
Washington, DO 5. Social Security Number 46 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** Days 1 🕱 M 2 🗆 F Min. Hours Director -9887 579-4 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 No MD Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6000 Quintana Street 20737 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 X Married þ 2 □ No Korean Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🖾 No Year or Dates. **Victnam** permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Service Representative Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles E. Daniel, Sr. Ledra Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Daniel / Wife 6000 Quintana Street, Riverdale, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 7/1/2011 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 RAY Royans Gasch's Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Carcinoma of the Prostate Metastatic Physician/ year Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Directo for as a consequence off frankledding to himself cause. Enter Underlying Cause (Disease or iinjury and the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Director: After this certificate 25, Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **30**00 ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Dire Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar MD

D 37934

7500 Greenway Center

20770

Drive Suite 430 Green belt MD

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

te

31. Date filed (Month, Day, Year)

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2011

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yla	Meni Meni narke	ř	Thomas F. Elle			·			Ma	rtha	Jean C	arte	r		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Sp 21, Signifure of Fu) IS		Laur								r Deeri	ield, NJ	
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	1		30, Name and address of person when	no completed cause of de	ath (Item :	23a) (Type, F	rint)	- / _	\'_					12011	
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State of Maryland / Department of Health and Mental Hygiene State
Registra 22489 Certificate of Death Reg. NZ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 201<u>1</u> Physician/ Month 24 1:25 Pm M Elizabeth Anna Gravenor June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Wicomico Salisbury Wicomico Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Days Hours Min Director 213-22-8652 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director MD Wicomico 1 Tes 2 No Pittsville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be with Funeral 8998 Stockley Road 21850 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. white 3 X Widowed 4 ☐ Divorced Specify Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) poultry farmer Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is meriany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George B. Holston Lydia Ellen Wyatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elton R. Gravenor (Son) 8908 Stockley Road Pittsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Line Cemetery June 28, 2011 Delmar, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Short Funeral 13 East Grove Home Street Delmar, DE Part 1. Enter the disease, or complesshock, or heart allure. List only one aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ailure. List only one ca ose on e Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 month Day Pregnant at time of death Month Year g 🔲 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 Yes 2 No 2 1 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 1 No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Tes 2 🗌 No I Director: # Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Mgnth, Day, Year) 310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 910 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar JUN 28

			1 - For State of Maryland /		ertment of			giene Reg. N.20		22490
	-		Negistrar 1. Decedent's Name (First, Middle, Last)			Death	2. Date of Dea	ıth	1 1	3. Time of Death
	Physici /Medi		Clyde Nelson Gilbert, Sr.				June	22, 2	$2\overset{Year}{0}\overset{1}{1}$	8:23 P.M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Dea	ath	4c. County	of Death	
and .			1494 West 10th Street 5. Social Security Number 6. Sex 7. Age (In vrs. last I	6:-464X	Freder		S O Bata of Bird	Frede		
Н	Funeral Director		5. Social Security Number 6. Sex 1.5 M 2 F 7. Age (In yrs. last I	Yrs.	Months Days			932	9. Birting Cour	place (State or Foreign otry) VA
	P		Usual Residence of Decedent				02/02/			
	arylar show	-	10a. State 10b. County 10c. City, To	wn or Loc	cation				1	0d. Inside City Limits 1 No 2 No
	the Mi	Director	MD Frederick Fred	leric				10 000		
	with sa or				10f. Zip Code			10g. Citizen of	wnat Cour	ntry?
	death ms 2;	Funeral	1494 West 10th Street 11. Marital Status 12. Was Decedent Ever in U.S.	13, V	21702 Vas Decedent of	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	USA 14. Rad	ce - Americ	can Indian,
9	or ite		Armed Forces? 1 □ Never Married 2 ☐ Married 1 □ Yes 2 ☐ No	- 1	Yes, specify Cul		rto Rican, etc.)		ck, White,	etc.
000	ural",	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:					Specif	Wh	ite
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pu	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evertine roughly not the Medical Evertine roughly not the Medical Evertine roughly.	Be	17. Father's Name (First, Middle, Last)				ame (First, Middle,	Maiden Surnan	ne)	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.						Rural Route Numbe			
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a E	permit. Departrimporta any inju		21. Signature of Funeral Service Licensee				Stauffer			
<u>m</u>	89 = 8		Ceshil a. Mr				ike, Fre		MD 2	21702
П			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dy	ing, such as cardia	ac or respiratory ari	rest,		Approximate Interval Between Onset and Death
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⋝ ∶	nysici nis cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital; 1 ☐ Inpatient 2 ☐ ER/C	Outpatient	3 □ DOA Oti	her: 4 \(\sum \) Nursing		ence 6 🗆 Oth	ner (Specif	~ な)
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DIVISION	after d Direc	Certification:	4 Homicide determined 28e. Place of Injury - At home, 1	farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Numb n, State)	er or Rura	al Route Number,
	to the trought and waterland prysician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	edical C	29a. Certifier (Check only and properties) (Check only and	ge, death	occurred at the t	ime, date and place	ce, and due to the c	ause(s) and m	anner as s	stated.
	thin 2, the F	Medi	one) and manner stated. 29b. Signature and fittle of certifier							
F	= ≥ F 8	_	The Man I ha		29c. Licen:			19d. Date signe		
	5		30. Name and address of person who completed cause of death (Item 23a)) (Type, P	rint),	1.		juile 2	1	
	9 Stat	9	30 WEST NINT Shreet	ME	derch	IMP	; AUBA	NE J.	NAC	oy, Mo
	Registra		JUN 28 2011 Lynn B.	100	when	1				

11-05015 Daniel Kelly Grimes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certifica	te of Death	Reg. No.	011 22431
Physic Medical Exam		1. Decedent's Name (First, Middle, Last) Daniel Kelly Grimes		Date of Death Month Day	3. Time of Death 1523 hrs
Annual Control		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 5, 2011 4c. Cour	nty of Death
		3408 Rogers Avenue	Ellicott City	Howa	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		(YY) 9. Birthplace (State or Foreign
		216-82-5969 1 M 2 F 50	Yrs.	07/18/1960	Country) MD
v any		10a. State 10b. County 10c. City, Town of			10d. Inside City Limits
rland -f shov	ξ	MD Frederick Fr	ederick		1 X Yes 2 No
e Mary or 28a	Director	10e. Street and Number 6133 Springwater Place, Unit L	10f. Zíp Code 21701		What Country?
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.			13. Was Decedent of Hispanic Origin? (Sp		d States
death or item	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		hite, etc.
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2 =	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of w uring most of working life. DO NOT use retir	vork done 16b. Kind of red)	Business/Industry
15-0036 filed within 72 Hygiene. d other than '	Completed	12 D	istrict Store Manage	er Ren	tal Company
MD 21215-0036 d 2 should be filed within 72 hou lth and hornal Hygiene, n 27 is marked other than "aut numatic event, the Medical Exa	Be Co	17. Father's Name (First, Middle, Last) Pearl Ambrose Grimes, Jr.		(First, Middle, Maiden Surna	me)
	To B		Mailing Address (Street and Number or R	ta Comegys Rural Route Number, City or T	own, State, Zip Code)
and 2 shou lealth and ?		David Grimes / brother 1	78 Stoneybrooke Ct.	, Frederick, I	MD 21702
E : : : : :		20a. Method of Disposition 20b. Place of 1 Burial 2 Cremation 3 Removal from State cremator	Disposition (Name of cemetery, y or other place)	Date 20c. Location	on - City or Town, State
Baltimore, permit. Pages I ar Department of Hea Important: If ite injury or other tr		4 Donation 5 Other Specify: Smith 21. Signature of Funeral Service Licensee	sburg Crematory 7/9	9/2011 Smith	sburg, MD
Bal permi Depa Impo injur		MO1222	106 E. Church Stre		
Physician		23a. Part / Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such es cardiac or	respiratory arrest, shock, or	heart Approximate Interval
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	iner	Sequentially list conditions, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause			
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687(ertifica ding pt		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnar		of delivery n Day Year
Box 68' death certificate at the death certificate death certificate death certificate death dea	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
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ttendii death. ctor: /	atio	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No		
Division of Vital Records, talor Attending Physician: The law require rs after death. al Director: After this certificate has been siled in by the functal director, page 2 should be	Certification:	determined (Specific)	n, street, factory, office building, etc.	 Location (Street and Nur or Town, State) 	mber or Rural Route Number, City
Hospital (4 hours a Funeral I ely filled		4 Homicide 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	due to the course(s) and man	
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certification of Attending Physicians of the law requires that the death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred at	the time, date and place, end	d due to the cause(s)
F 2 F 0	ž	29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)
		Totruci Gronica- Poll	O.C.M.E.	July 6, 20	011
		 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examir 	ner 900 W. Baltimore Street, Ba	altimore, MD 21223	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist	rar	JUL 1 4 2011 Sever D. Jane			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&c Per FH G917 //20/2011 JH. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ -Month Violet J. Hutt 30 M Medical 8 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisburg Rehabilitation Wursing Ctr If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 □ M 2 🛣 F 2-8-1926 Months Hours Min Director 216-16-7916 85 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21804 USA 812 South Schumaker Drive permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important if frem 27 is marked other than "nature" any injury or other traumatic executions. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married If Yes, Give Year or Dates Yes 2 XNo Specify: SpeBlack Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Birds Eye Co. 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Agnes Parsons Clarence Hutt, Sr. 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Poplar St, Apt 3C, Fruitland, MD 21826 Joyce Hutt-Ellison 0 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Snow Hill,Md Scoretery, comparory or other clace)
Flower Hill Cem 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 7-2-2011 21. Signature of Funeral Vice Light See 22. Name and Address of Facility Bennie Smith Funeral Home Isabella St. 917 W. Salisbury MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician 0 disease or condition resulting in death) car Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate Examine Due to (o as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached it Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? To the Funeral Director: After this certificate completed filled in by the funeral director, pag Yes 2 No 1 Yes 2 🗌 No al or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 JH6 Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 \(\subseteq \text{Yes} \) 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jilliam D Robins JUN 27 egistrar's Signature State Registrar

11-05039 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Sterling Hess State of Maryland / Department of Health and Mental Hygiene 22493 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month D July 6, 2011 1610 hrs **Medical Examiner** John Sterling Hess 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 14117 Misty Meadow Road Smithsburg Washington If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Foreign Davs Pa. Director April 18,1990 Country) 21 215-29-7974 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Smithsburg 1 Yes 2 Y No Md. Washington 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21783 U.S.A 14117 Misty Meadow Rd. 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Y Yes White 3 Widowed 1 Yes 2 V No specify: Specify 4 Divorced Give Year ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plumbing Baltimore, MD 21215-0036 Plumber 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Tammy L. Belew Merle William Hess Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14117 Misty Meadow Rd. Smithsburg, Md. 21783 (Mother) Tammy L. Reed 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Y Burial 2 Cremation 3 Removal from State July 11, Ringgold Cemetery Ringgold, Md. 4 Donation 5 Other Specify: 2011 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval art I. Enter the disease, or complications Physician Between Onset and failure. List only one cause on each line. /Medical Death Immediate Ceuse (Final disease a Narcotic (Morphine) Intoxication xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any leading to immediate attending physician or use as the burial -Medical Certification: To Be Completed by

Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the attenderal director, page 2 should be detached for it To the Funeral Director: completely filled in by the

Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
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Part II. Other significant condition	1Y. 24a. Wa	opsy prior to completion of cause of formed? death?
25. Was case referred to medical	26.Place of Death (Check only one)	
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	(Month, Day, Year) fd 7-6-11 fd 3:00 pm 1 Yes 2 No Unknow	e how injury occurred
3 Suicide 6 X Could n 4 Homicide	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location	(Street and Number or Rural Route Number, City State) 14117 Misty Meadow Rd. Durg, Md.
	ician: To the best of my knowledge, death occurred at the time, date and place, and due to the carer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dat and manner stated.	
20h - 01	200 Lineage Turnber	20d Data signed (Manth Day Vand

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

July 7, 2011

State

Registrar

Assistant Medical Examiner

32. Registrar's Signature

Melissa Brassell, MD

4 201

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 29, Physician/ 11:10¹² Marie Irvin 2011 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Williamsport Williamsport Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 8-14-1917 1 M 2 K 93 Clear 216-80-8166 Spring Director <u>d</u> Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than "----10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Williamsport 1X Yes 2 ☐ No 10f. Zip Code 21795 10g. Citizen of What Country? U.S.A. 10e. Street and Number Funeral 154 North Artizan Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify. 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) personal Elementary/Seconday (0-12) College (1-4 or 5+) residence 8th grade homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bertha Moon Harry Rowland Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 88 Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type, Print) David Irvin Sr. son 20b. Place of Disposition (Name of cemetery, crematory or other place)
BlairsValley Cem 20c. Location - City or Town, State Clear Spring, 7-6-2011 20a. Method of Disposition 11 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) MD 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my animal death associated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar MASTIZAN

egistrar's Signatur

WILLIAMSPOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howe

31. Date filed (Month) Pry, Yey) 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22495 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OYSIUS Jordan Medical 26 June 9:35 a.mM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mary's Hospital <u>Leonardtown</u> Mary's **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/28/1923 If Under 1 Year If Under Birthplace (State or Foreign Country) 1 X M 2 □ F Days **Director** 212-24-4387 88 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland St. Mary's 1 Yes 2X No Valley Lee a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 45458 Happyland Road 20692 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 27 is marked other than "natural", or ite traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 X No Race - American Indian. Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Specify: Black15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Alden Jordan Mary Jane Fenwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Meredith/Daughter 37647 Woodland Ford Lane, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George's Cemetery 07/02/2011 | Valley Lee, Maryland of Fuperal Service Livens 22. Name and Address of Facility Brinsfield Funeral Home, P.A. dward N. Brinsfield. Jr. 22955 Hollywood Road, Leonardtown, MD M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Retroperitoneal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pulmonary Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Coronary that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Prostrate Carcinoma IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 L g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Funer completed fi 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) J t D68923 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Vijaya Guduri,</u> 25500 Point Lookout Road, Leonardtown, MD

DHMH 17 Rev 7/2009

State

Registrar

JUN 29

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22496 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 3, 2011 1:50 PM <u>Dennis Edward Jackson, Sr</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, ec. 27 1 XM 2 □ F 65 Hours 1945 Florida 585-10-8932 **Director** Dec. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nother 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗆 Yes 2 🔀 No Maryland St. Mary's Lexington Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 21895 Pegg Rd. 20653 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify White Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, University of Elementary/Seconday (0-12) College (1-4 or 5+) Foreman Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zeb C. Jackson Erma Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Jackson/Wife 21895 Pegg Road, Lexington Park, MD 20653 1 Burial 2 Cremation 3 Removal from State 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Trinity Memorial, July 7, 2011 gärdens Waldorf, MD Sign for re of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ARTERY Physician CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERCIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): HYPERTENSION attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): HELLITUS by Physician/Medical DIABETES Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the firector, page 2 s autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: Certificate: To 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Mendono 20060638 715/2011

State Registrar

DHMH 17 Rev 7/2009

110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nanyantara Mendonca.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GEORGE M. **JONES** 5:41 \mathbf{A}_{M} Medical JUNE 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Loving House Hyattsville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Days 1 X M 2 🗆 F Hours (Month, Day, Year) 1916 **Director** <u>216-62-4807</u> 95 Washington, DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d, Inside City Limits MD Prince George's Hyattsville 1 X Yes 2 □ No 10e. Street and Number 10f, Zip Code ral", or items 23a o Examiner must be 10g. Citizen of What Country? Funeral 4870 66th Avenue 20784 IISA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces þ 1 X Never Married 2 Married Black White etc. Yes Yes, Give Baltimore, Maryland 21215-0036 2 🗌 No 1 ☐ Yes 2 No Specify: **Black** "natural" Completed 3 Divorced 4 Divorced Year or Dates. WW-II the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Messenger US Government other of Health and Mental Hygi of Health and Mental Hygi fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) of Health and Mental H
fitem 27 is marked ot
r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) 2 Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina C. Forbes - Attorney 1629 K Street NW, Ste 300, Washington, DC 20006 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/11 Metropolitan Crematory Alexandria, Virginia permit. Signature of Funeral Service Licensee 4739 Baltimore Ave. 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ ADVANCED DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTIVE PULMONARY DISEASE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚨 Unknown SCHIZOPHRENIA WITH PSYCHOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo 1 Yes 4 □ Nursing Home 5 □ Residence 6 ☒ Other (Specify) Living Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide ieral Director: / filled in by the f Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

JUL 0 1

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

29c. License number

MD# 33255

29d. Date signed (Month, Day, Year)

JUNE 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22498 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE DOROTHY T. KAMINSKI 2011 P^{M} 10:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 229 NORTH UNION AVENUE HAVRE DE GRACE HARFORD Social Security Number 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1<u>920</u> 91 Days Hours Min JAN 28 Months 201-03-3409 Director PENNSYLVANIA Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MARYLAND HARFORD 1 X Yes 2 ☐ No HAVRE DE GRACE 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 229 NORTH UNION AVENUE, APT 1B 21078 UNITED STATES Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHTTE 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ᅙ JAMES MORETTI ANNE MARIE MAHER and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 f Health item 27 NANCY A. KINDER / DAUGHTER 229 NORTH UNION AVE., APT 1B, HAVRE DE GRACE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite cemetery, crematory or other place) 5 1 🗆 Burial 2 ីX Cremation 3 🗔 Removal from State injury o R.A. FERRIS & CO. 4 Donation 5 Other (Specify) 6/29/11 WEST CHESTER, PA 21. Signature of Funeral Service Licenses Name and Address of Facility
ZELLMAN FUNERAL HOME, P.A any WASHINGTON ST. HAVRE DE GRACE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ eau co disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Serventially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.
Euneral Director: After this certificate has perform 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at injury 1 Natural 5 Pending wor 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title 29c. License number

Registrar

State

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ess of person who completed cause of death (tem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22499 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ Month June Sadia A. Laidley 4:10 Рм 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) eb. 16, 1 🗆 M 2 🛣 F Days Hours Min. Panama 069-38-6365 78 Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 13908 Lake Meadows Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗷 Yes 2 🗆 No Specify: Panamanian If Yes, Give Specify: **Black** Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing 10 Nurses Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Etheldra Francis James A. Laidley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13908 Lake Meadows Drive, Bowie, MD Pauline Green / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Maryland National Cemetery 7/3/2011 Laurel, Maryland 4739 Baltimore Avenue 21. Signature of Funeral Service License 22. Name and Address of Facility laudette Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the ail Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page 2 certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 Hospital: Other: မှ 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопретед 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number death (Item 23a) (Type, Print)

State Registrar 7 CO

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physici ledical Exami	an/	Decedent's Name (First, Middle,Last) HARRY AUGUST LABHART					2. Date of Death	n Day Yea		Time of Death 0803 hrs		
Shi .		Facility Name (if not institution, give street and number) Market Street				b. City, Town Aberdeer		of Death		4c. County of Harford	f Death	
Funeral Director		5. Social Security Number 317–14–0877	6. Sex	7. Age (In yrs. I	ast birthday) 37 Yrs.		ear If Un ays Hou	der 24Hrs. rs Min.		/1924	Foreign	lace (State or try)INDIANA
ryland is-f show any it once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. MARYLAND HARFORD 10e. Street and Number			City, Town or Location ABERDEEN 10f. Zip Code				10d. Inside City Lim 1 Ves 2 1			
h with the Maryland ms 23a or 28a-f sho be notified at once	uneral Dire	14 MARKET STREET 11. Marital Status 1 Never Married 2 X Married Armed Forces?		cedent Ever in U.				rigin? (Spe				
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23s or 28s-f short rammatic event, the Medical Examiner must be notified at once	by F	1 Never Married 2 No 3 Widowed 4 Div 15. Decedent's Education (Spe	² No No 1942–4	12-46 1 Yes 2 X No specify:				Specify: WHITE 16b. Kind of Business/Industry				
5-0036 led within 72 hor Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) 17, Father's Name (First, Middle	2	1-4 or 5+)	during mo	ENGIN	IEER				OVERI	NMENT
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	To Be C	HENRY LABHART 19a. Informant's Name/Relations	hip (Type, Print)	18.Mother's Name (First, Middle, Maide LEONA THOMPSON Print) 19b. Mailing Address (Street and Number or Rural Route Number,		per, City or Towr						
Baltimore, MD 2121 permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other transmatic event,		BILLIE M. LABE 20a. Method of Disposition 1 Burial 2 X Cremation		20b. I	Place of Disposi crematory or oth	tion (Name of er place)	cemetery,		Date	20c. Location -	City or To	wn, State
Baltimore, permit. Pages I at Department of Het Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service		IR.	A. FERR				1/11 HOME, P J. STREE			TER, PA GRACE, MD
Physician Examiner	Examiner	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	on each line. a. Atheroscle Due to (or as a b. Due to (or as a c.		rascular Dise f): f):		ng, such as	cardiac or	respiratory arre	st, shock, or hea	rt	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Med	F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d.								/ Year		
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Division of Vital tal or Attending Physician rs after death. al Director: After this certifed in by the funeral director.	ြ	o 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other: Scene							cene			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	The state of the state of the state of my knowledge, death occurred at the time, date and place, and the to the cause(s) and manner as								Route Number, City			
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only	hysician: To the beaminer: On the basis and manner ser	of examination a	-	on, in my opin		ccurred at			e to the c	
0 1 1 1/A		30. Name and address of person		•	,		C.M.E.			June 28, 20		
3+1VA St Regis	ate	Carol Allan, MD As	sistant Medical	Examiner signature			et, Baltim	ore, MD	21223			

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